A MODEL FOR PERCEIVED COALITION EFFECTIVENESS: THE RELATIONSHIP OF COALITION VARIABLES TO PREDICT CANCER COUNCILS' ORGANIZATIONAL CAPACITY TO ACHIEVE EFFECTIVE COMMUNITY OUTCOMES

A Dissertation

by

WILLIAM ALVIN TORRENCE

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

December 2005

Major Subject: Health Education

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ABSTRACT

A Model for Perceived Coalition Effectiveness:

The Relationship of Coalition Variables to Predict Cancer Councils' Organizational Capacity to Achieve Effective Community Outcomes. (December 2005)

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Public Health has long led the fight against unjust health disparities within the United States. More and more health educators have had to rely on the social capital of underserved communities via Community Coalitions. Throughout this study, the significance and growth of coalitions and its importance within the field of Public Health was highlighted. The purpose of this study was to test the operational constructs within the Community Coalition Action Theory (CCAT), mainly the constructs of 1) stages of coalition development, 2) membership engagement, 3) leadership, 4) coalition structures & processes, as well as 5) perceived coalition ownership in explaining 6) perceived coalition capacity effectiveness (dependent variable). Results of this study revealed that perceived coalition capacity effectiveness was best predicted by stage of coalition development and perceived coalition ownership. This model accounted for 55.5% of the variance within this study when explaining the high impact participants achieved in regard to their perceived coalition capacity effectiveness.

DEDICATION

The “blood, sweat, and tears” that embodied the “sacrifice” and “tribulations” that led to this work are truthfully and honorably dedicated to my God, family, friends, mentors, teachers, professors, and to the countless individuals, communities, and societies that are affected by the injustice in which our Public Health/ Health Care system is currently practiced!

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INTRODUCTION

Coalitions have always existed throughout the civilization of humankind, yet formal coalitions related to community action within the United States arose during the 1960s. The 1960s was a chaotic decade which seen the rise and fall of leaders like Robert Kennedy, John F. Kennedy, Rev. Dr. Martin Luther King, Malcolm X, and Muhammad Ali. During these times, there was enormous grassroots pressure to create a power base for social services through political advocacy. This process led to the formation of formal coalitions that operated democratically to change community norms. As a result, political and social programs emerged from these "grassroots" organizations that defined not only their particular community problems for themselves; they also developed their own community tailored solutions to these problems (Armbruster, et al., 1999). Coalitions served as strategic social and political devices formed in order to enhance the advantage of various organizations with regard to some particular issue(s) or problem(s). Historically, coalitions promote and coordinate activities that include both individually targeted and environmentally targeted interventions. Individually targeted interventions include activities such as diabetes awareness, mammography screenings, sexual health, or violence prevention.

This dissertation follows the style of *Health Promotion Practice*.

These activities have an identifiable priority population and a specifically tailored intervention. Environmentally targeted activities include social marketing, media campaigns, or non-priority population specific interventions that raise awareness or influence attitudes against adverse health outcomes related to the tailored individually targeted interventions (Gabriel, 2000). The distinction that coalitions carry with them in regard to health promotion is that their primary goal is to influence community-wide outcomes related to knowledge, attitudes, beliefs, and practices.

In order to understand the origins of coalitions, one must first define the various meanings and definitions that coalitions have succumbed to over the years. As a social change agent, coalitions are often characterized as an organization of organizations whose members commit to an agreed-on purpose and collectively share decision-making task in order to influence an external goal or target while still maintaining their own autonomy as separate organizations (Mizrahi & Rosenthal, 2001). The preferred definition of coalitions is that it is constructed of individuals representing a multitude of diverse organizations and community sectors (Butterfoss et al., 1993). These interorganizational entities strive to build community confidence, community competencies, and social connections within there shared community. They achieve this through broad participation via the various agencies and stakeholders in an effort to promote a unified ownership of the particular problems the community shares. The expansion of resources, commitment, expertise, and awareness gives way to a synergistic effort to sustain long-term health promotion actives and programs that will extend beyond individual lifestyles and influence the overall social policy within the

community. Essentially, coalitions provide a framework for the development, implementation, and evaluation of health programs tailored to local conditions (McLeroy, et al., 1994). The rise of coalitions as a primary and prominent health promotion strategy parallels the growth of community wide health promotion over the past two decades via the leadership of such entities as the National Institutes of Health, Center for Disease Control and Prevention, and Healthy People.

Types of Coalitions

As stated previously, the history of coalitions has to be understood and critiqued with attention to the type of coalition being analyzed. Coalitions are classified in numerous ways, yet the major classifications of coalitions are by membership, function, and organizational structure. When classifying coalitions by membership, three major groups tend to stand out in the literature, they are grassroots coalitions, professional coalitions, and community-based coalitions. Grassroots coalitions are organized by citizen volunteers in response to particular crisis or to pressure policy makers to take specific actions. They tend to be controversial and very volatile. They are very issue orientated and partisan in their agenda and approach. Professional coalitions are those formed by professional organizations in response to particular crisis or as a long-term approach to solidify or increase their power and influence. Community-based coalitions (community coalitions) tend to be a mixture of grassroots and professional organizations that form to influence more long-term health and welfare issues that will benefit their mutual community. They are usually initiated by a lead agency or a group of agencies in

response to a funding proposal or prioritized health or social welfare issue. The latter coalition tends to dominate the active coalitional type that is utilized throughout health education and promotion (Butterfoss et al., 1993).

When defining coalitions according to their function, there are overlaps that tend to make this classification system ambiguous. The various functions that coalitions perform in which they may be classified include information and resource sharing, technical assistance, self-regulating, planning and coordinating services, and advocacy (Butterfoss, et al., 1993). Yet, given the variable that most organizations that join coalitions tend to have diverse ideologies, resources, goals, and needs; most health promotion coalitions perform more than one function and thus cannot be classified solely according to its coalitional function.

The classification of coalitions based on organization structure centers around the way in which the organizations relate to each other within the coalition. The types of organization structures are organization-set coalitions, network coalitions, and action-set coalitions. Within organization-set coalitions, groups within the coalition provide resources of services under the guidance of a lead agency or organization. They tend to follow the lead of the lead agency, yet they do maintain a democratic and autonomous role in the activities or the coalition. Network coalitions are comprised of organizations with loose, informal connections that only interact for a specific purpose. They tend to be more for service navigation purposes, rather than goal or issue orientated. Action-set coalitions are issue specific and ad hoc in nature. Organizations come together to form coalitions in order to act in accordance to a specific purpose, develop a common identity,

or in response to an adverse health effect that cannot be dealt with by any one organization or agency. Organization-set and action-set coalitions tend to form permanent coalitions with central staff, leadership, and resources that define its standard of operations. Network coalitions tend to be informal and primarily used for information sharing and group strategies with the autonomy of the individual agencies maintained (Butterfoss et al,, 1993).

Presently within the field of public health, community coalitions tend to be synonymous with community collaboration,community partnerships, and community networks. A partnership is defined as a formal alliance of organizations, groups, or agencies that have come together for a common goal (Butterfoss, et al., 1993). Collaboration is simply the term used when a group works jointly with another group in order to achieve a specific task through shared responsibility (Ansari, et al., 2001). Conversely, partnerships, collaborations, and networks are all interchangeable with community coalitions when the following conditions are met: 1) the shared entity is made up of individuals or groups representing diverse stakeholders of independent community organizations or professions; 2) the inter-organizational structure is truly democratic and all stakeholders have equal stake; 3) the governing body is elected democratically by all stakeholders; and 4) membership in the coalition is totally voluntary. In essence, the above models have the potential to serve as an effective strategy for gaining the support of the public for public health and for initiating planning efforts for health education, prevention, protection, and promotion activities (Berkowitz, 2000). Throughout the rest of this manuscript, coalitions will be synonymous with

community coalitions that will be define as: a group of individuals representing diverse organizations, factions, or constituencies within the community who agree to work together for a specific purpose and/or to achieve a common communal goal (Butterfoss & Kegler, 2002).

According to the coalition literature, there are several ways in which coalitions enhance health promotion's capabilities to develop and implement community interventions. First, coalitions become enablers where about they become involved in new and broader issues without having the sole responsibility for managing or developing the issues. Second, coalitions galvanize widespread community support for issues, actions, and solutions. Third, coalitions maximize the power of individuals and groups through synergistic action that enhances the critical mass behind community efforts by helping individuals achieve objectives beyond the reach of any one individual or organization. Fourth, coalitions minimize duplication of efforts and services within a community by enhancing and consolidating trust and communication among groups that would normally compete with one another. Fifth, coalitions mobilize more talents, resources, and approaches to influence and solve complex issues than any single organization could achieve alone. Sixth, coalitions provide the structure in which recruiting participants from diverse political, ethnic, racial, religious, and professional backgrounds can be achieved. Seventh, coalitions provide the flexibility of which allows them to utilize new resources in dynamic situations (Butterfoss, et al., 1993). Coalitions enable communities to build capacity and intervene utilizing a social ecological approach (McLeroy, et al., 1988).

Coalition Framework

The framework of community coalitions center on social health issues that are guided by a purpose. This particular rationale is what distinguishes a coalition from other informal group of organizations. The basic foundation of any coalition is the shared understanding of why the proposed coalition is in the individual organizations' best interest (Roberts-DeGennaro, 1986). The purpose of the coalition formation should guide the member organizations in their objective to achieve social change. According to Roberts-DeGennaro, Coalitions can be perceived as social change agents only if their participants are directed toward a purpose, other wise, a loosely coupled group of organizations will emerge rather than a goal-directed coalition (1986). Coalitions are action-oriented to a process by which decisions are made, resources are shared, and synergistic activities bring about the social change in which the coalitional purpose was founded.

According to Krueter, et al., review of coalition literature, most arrangements in public health are driven by outside funding sources for a particular set of health activities and outcomes (2000). Initially, there are three proposed stages that influence the framework of community coalitions: problem setting, direction setting, and implementation (Butterfoss & Kegler, 2002). Revisiting the conceptual framework of coalition formation in regard to coalitional purpose, there are five components that stand out above all other attributes. These building blocks are conditions, commitment, contributions, competence, and capacity. Stated previously, in order for a coalition to form, there have to be ideal political, economic, or community conditions that spark the

organizational flame that grows into a coalition. In addition to the above conditions, the type and level of resources possessed by the organizations; past experiences with former alliances; the urgency of the social change goal; and feasibility of obtaining a tangible outcome dictates coalition formation (Mizrahi & Rosenthal, 2001). Commitment is a component that characterizes the relationship among the organizations in regard to self-interest and altruism, and between pragmatism and ideology. The pragmatic motivation is characterized by the collection of resources and power to further ones agenda. The ideological motivation usually is dictated by a value-based commitment that is rooted in the social justice philosophy that guides public interest (Mizrahi & Rosenthal, 2001).

Contributions of member organizations within the coalition are very relevant and important. The literature points to three types of contributions that benefit coalition formation. They are resources, ideology, and power. Resources consist of not only the tangible sources of staffing and funding, they also include intangible sources such as expertise, information sharing, and inter-organizational training. Ideology, as stated above plays a major role in the formation of the purpose of a coalition. It influences the formation of specific coalition goals, sets the tone for the interaction and decision-making process, and defines the level of commitment the coalition will possess. In essence, the ideology will guide not only the image of the coalition, but also the requirements of the organizations that will comprise the coalition. The aspect of power is very vital in that it is necessary in order for the coalition to influence its external goals and outcomes. Coalitions themselves have to maintain the balance between exacting the autonomy to take independent action and remaining accountable to the member

organizations. The actual power of a coalition lies with the collective power synergized from the member organizations (Mizrahi & Rosenthal, 2001). Yet, this power can become so independent, that member organizations may no longer hold principle stakes in the decision-making process.

When assessing the principle building blocks of coalition formation and function, competence tends to stand as the "maintenance" of the coalition framework. The complexities involved in the maintenance of a coalition rest in the coalition's ability to 1) sustain movement toward external goals and outcomes, 2) maintain internal relations among the principle organizational representations, and 3) develop the trust with, accountability to, and contributions from the coalition membership foundation (Mizrahi & Rosenthal, 2001).

In addition, coalition capacity has to be maintained in order to enact the social change, practice, service, program delivery, or system navigation that it was founded to perform. Coalitional capacity refers to the potential or readiness of a coalition to address health improvement, not necessarily its competence in doing so. Capacities are those components necessary for the coalition to carry out its mission and its vision, such as leadership; planning processes with clear outcomes, priorities, and goals; readiness and experience; and systematic communications. Inherent in coalition capacity, as well as coalition competence is building and sustaining the infrastructure necessary to support the activities of the coalition. The sustainability of community coalitions require six elements: 1) access to educated and skilled individuals; 2) human and financial resources; 3) information and communication systems; 4) process for engaging

community members in policy development; 5) research; and 6) processes supporting policies for community development and involvement (Berkowitz, 2000).

Inherent in coalitional capacity and sustainability is its ability to manage competing and sometimes conflicting interest of power in regard to member organizations within the coalition, as well as how they relate to their primary constituents. Coalitions have to contend with conflicting issues in regard to mixed loyalties, autonomy versus accountability, means versus model, unity versus diversity, scarce resources, and dependence versus independence. Mixed loyalties are manifested because member organizations are expected to have a dual commitment to both the coalition goals, as well as their own organizational goals. The conflict of autonomy versus accountability arises because coalitions must have enough autonomy to take independent action, yet still remain accountable to the member organizations within the coalition. Unity and diversity are at odds sometimes because coalition members may share compatible interest, yet they may not be identical. There may be diverse self-interests that guide member organizations that may work against coalition unity. When resources are scarce, member organizations are often at war between committing limited time and resources to other organizations outside of their own or retaining resources to intra-organizational activities only. The relationship of dependence versus independence that occurs between the coalition and its lead agency can be unstable. The coalition is dependent on the regulations and expectations of the lead agency. The interest of the lead agency and the coalition may not be the same (Chavis, 2001).

Theoretical Background

Community development and related approaches such as community organization, community empowerment, community capacity building, and citizen participation provide the foundational philosophy that underlies community coalition approaches (Butterfoss & Kegler, 2002). The community development movement was conceived by the United Nations in 1955 and was designed to create conditions of economic and social progress for the whole community with its active participation in the community initiative. The community development approaches were based on the assumptions that communities can develop the capacity to deal with their own problems; people should participate in decisions that take place in their communities; and changes in community living that are initiated within the community have greater impact than imposed changes outside of the community. These paradigm shifts gave way to the formation of community coalitions that can demonstrate and develop community support for issues; maximize the power of individuals and groups through collective action; improve trust and communication among community agencies and sectors; mobilize diverse talents, resources, and strategies; build strength and cohesiveness by bridging individual activists; build a constituency for a given issue; reduce the social acceptability of health-risk behaviors; and change community norms and standards (Butterfoss & Kegler, 2002). All of the above led to the development of the Community Coalition Action Theory (CCAT) (Figure 1).

The Community Coalition Action Theory (CCAT) enables communities to build capacity by utilizing a social ecological approach. This theory applies only to

community coalitions as defined earlier in this manuscript. If a group is composed solely of individuals and not organizations, then it is not a coalition in its purest form and this theory may not be appropriate. The CCAT, as explained by Butterfoss & Kegler (2002), focuses on aiding a community coalition in regard to its preventive, intervening, and educational activities by helping them to 1) analyze their particular problem or concern, 2) gather credible data via reliable assessments, 3) develop an action plan tailored to their particular situation, 4) implement effective solutions, 5) achieve community-level outcomes, and 6) affect social policy and community competence. There are approximately fourteen (14) constructs that comprise CCAT.

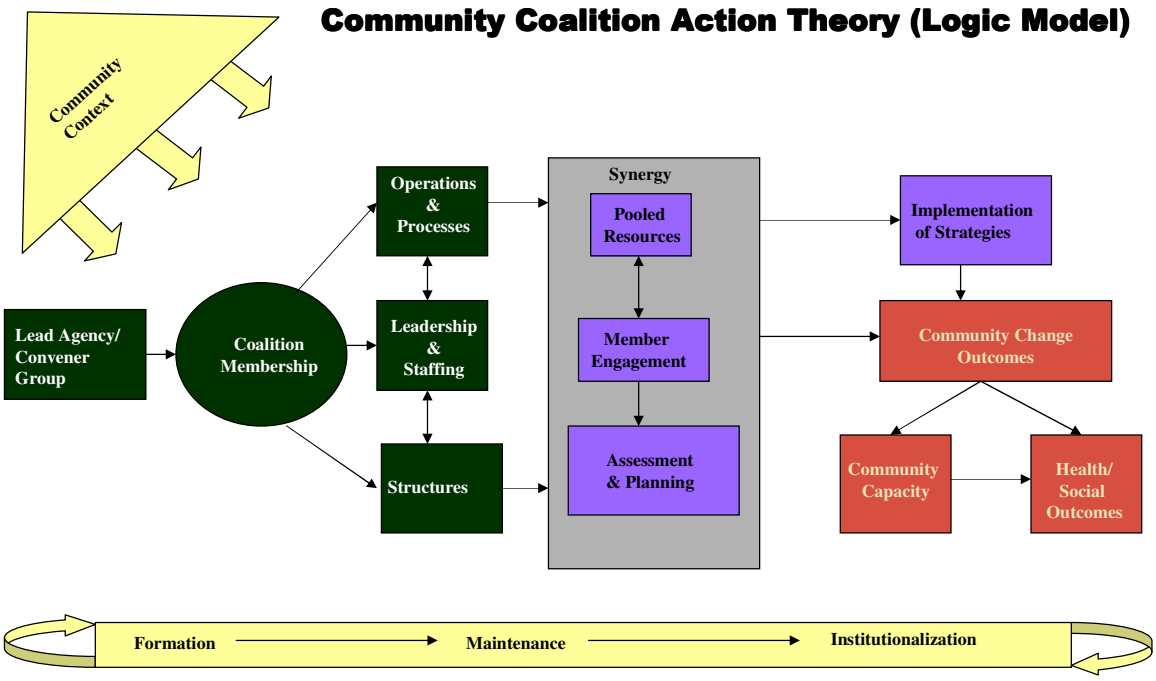


Figure 1: Community Coalition Action Theory Logic Model

These constructs center around the 1) stages of coalition development, 2) community context, 3) role of lead agency/ convener group, 4) coalition membership, 5) coalition operations and processes, 6) leadership & staffing, 7) structures, 8) pooled members and external resources, 9) member engagement, 10) assessment and planning, 11) implementation of strategies, 12) community change outcome, 13) health and social outcomes, and 14) community capacity. Within these fourteen constructs, there are 23 propositions that define this theory. The first sixteen propositions correlate with the first seven constructs and are related to community coalition formation, structure, and processes. The latter 7 propositions and 7 constructs are related to community coalition interventions and outcome.

When analyzing community coalition formation, structure, and process, the following constructs and propositions have to be considered:

Stages of development

> *Proposition 1.* Coalitions develop in specific stages and recycle through these stages as new members are recruited, plans are renewed, and new issues are added.
>
> *Proposition 2.* At each stage, specific factors enhance coalition function and progression to the next stage

Community context

> *Proposition 3.* Coalitions are heavily influenced by contextual factors in the community throughout all stages of development.

Lead agency/ convener group

> *Proposition 4.* Coalitions form when a lead agency or convening group responds to an opportunity, threat, or mandate.

Proposition 5. Coalition formation is more likely when the lead agency or convening organization provides technical assistance, financial or material support, credibility, and valuable networks and contacts.

Proposition 6. Coalition formation is likely to be more successful when the convener group enlists community gatekeepers who thoroughly understand the community to help develop credibility and trust with others in the community.

Coalition membership

Proposition 7. Coalition formation usually begins by recruiting a core group of people who are committed to resolving the health or social issue.

Proposition 8. More effective coalitions result when the core group expands to include a broad constituency of participants who represent diverse interest groups, agencies, organizations, and institutions.

Coalition operations and processes

Proposition 9. Open and frequent communication among stakeholders and members help to create a positive organizational climate, ensures that benefits outweigh costs, and makes pooling of resources, member engagement, and effective assessment and planning more likely.

Proposition 10. Shared and formalized decision-making processes help create a positive organizational climate, ensure that benefits outweigh costs, and make pooling of resources, member engagement, and effective assessment and planning more likely.

Proposition 11. Conflict management helps to create a positive organizational climate, ensue that benefits outweigh cost, and achieves pooling of resources, member engagement, and effective assessment and planning more likely.

Proposition 12. The benefits of participation must outweigh the cost to make pooling of resources, member engagement, and effective assessment and planning more likely.

Proposition 13. Positive relationships among members are likely to create a positive coalition climate.

Leadership and staffing

Proposition 14. Strong leadership from a team of staff and members improves coalition functioning and makes pooling of resources, member engagement, and effective assessment and planning more likely.

Proposition 15. Paid staff who have the interpersonal and organizational skills to facilitate the collaborative process improve coalition functioning and increase pooling of resources, member engagement, and effective assessment and planning.

Structures

Proposition 16. Formalized rules, roles, structures, and procedures make pooling of resources, member engagement, and effective assessment and planning more likely.

When analyzing community coalition interventions and outcomes, the following constructs and propositions should be considered:

Pooled member and external resources

Proposition 17. The synergistic pooling of member and community resources prompts effective assessment, planning, and implementation of strategies.

Member engagement

Proposition 18. Satisfied and committed members will participate more fully in the work of the coalition.

Assessment and planning

Proposition 19. Successful implementation of strategies is more likely when comprehensive assessment and planning occur.

Implementation of strategies

Proposition 20. Coalitions are more likely to create change in community policies, practices, and environment when they direct interventions at multiple levels.

Community change outcomes

> *Proposition 21*. Coalitions that are able to change community policies, practices, and environment are more likely to increase capacity and improve health and social outcomes.

Health and social outcomes

> *Proposition 22*. The ultimate indicator of coalition effectiveness is the improvement in health and social outcomes.

Community capacity

> *Proposition 23*. As a result of participating in successful coalitions, community members and organizations develop capacity and build social capital that can be applied to other health and social issues.

Throughout the numerous propositions that exist among the various constructs of the Community Coalition Action Theory (CCAT). The fundamental propositions and constructs center on the stages of coalition development. These stages of develop are classified as the formative stage, maintenance (implementation) stage, and institutionalization stage. For many coalitions, the stages of development are continuous and dynamic according to the issues at which the coalition are focused on. During the formative stage, the coalition identifies key leaders and staff, develops structures (such as mission, goals, committees, and rules) and operating procedures (processes) that promote coalition effectiveness. This particular stage requires balancing benefits associated with membership to ensure they outweigh any cost of participation from the individual organizations. The maintenance usually involves sustaining member involvement and taking steps to achieve the goals of the coalition. This stage's objectives center on assessing, planning, selecting, and implementing coalition

strategies. The institutional stage involves the evaluation of short-term and long-term outcomes. With the effectiveness of the coalition translated into effective community outcomes, coalition strategies may become institutionalized within a community via the coalition itself, or it may be adopted by some specific organizations within the community whom will be charged with continuing the work started by the coalition (Butterfoss & Kegler, 2002). In essence, the coalition itself may or may not be institutionalized in a community, yet it is vital that the work of the coalition become institutionalized within a community.

Coalition Effectiveness

Coalition effectiveness is a term that is often used in regard to the community coalition's formation, structure, and process effectiveness, as well as the community coalition's effectiveness of its interventions and outcomes within the community. It is a given that in order for community coalitions to be effective within their communities, the effectiveness of the coalitions have to be evident and translate into effective community interventions and outcomes. Yet, before these interventions and outcomes can manifest, coalition effectiveness at the formation, structure, and process level have to be precise, efficient, and effective (Gottlieb et al., 1993). When evaluating coalition effectiveness, much of the literature focuses on coalitional formation, structure, and process effectiveness. The effectiveness of coalition intervention and outcomes are usually evaluated according to the specific intervention that was developed by the coalition and tends to be evaluated without regard of the coalition itself. Because

coalition constructs have sociological, political, and organizational roots, the analysis of interpersonal dynamics plays an important role in the understanding of the fundamental skills necessary for successful coalition effectiveness (Mizrahi and Rosenthal, 2001).

Revisiting the framework of the Community Coalition Action Theory (CCAT), the construct stages of development (formation, implementation/maintenance, and institutionalization) forms the foundation for which an effective coalition is built. This is so mainly because the coalition's stage of development is directly linked to its function. Coalition formation, as discussed earlier, has the important task of articulating a clear mission and guiding the purpose of the coalition. The extent to which organizations share interest and needs determines greatly their effectiveness in carrying out their mission and purpose. Yet, if the coalition is founded on a "spirit of cooperation," it will be well on its way to becoming a cohesive and effective coalition (Butterfoss, et al., 1993). In addition to coalition formation, coalition implementation and maintenance tends to have the greatest factors that correlate with coalition effectiveness. The factors that contribute to effective coalition implementation and maintenance are coalition formality, leadership characteristics, membership characteristics, organizational climate, and relationships with external supports.

Coalition formality consists of the extent to which a coalition has formalized rules, roles, and procedures that support the purpose of the coalition's formation. The literature stresses that the assessment of coalition formality is based on written memoranda of understandings; by-laws; policy and procedures manuals; clearly defined roles, mission statements, goals, and objectives; and regular reorientation to the

purposes, goals, roles, and procedures of collaboration (Butterfoss, et al., 1993). The more formalized a coalition tends to be, the greater the investment of resources and exchanges among member organizations. In addition to the synergy of resources and exchanges, formalization also results in the routinization of the coalition's operating procedures. The more routinized coalition operations become, the more likely they will be sustained and produce effective interventions and outcomes (Goodman & Steckler, 1989).

Leadership characteristics are very important in regard to the maintenance stages of coalition development . Within every coalition, there tends to be a core group of individuals that take the lead and guides the coalition as role models and leaders. Leadership constructs that affect coalition effectiveness are personal resources such as self-efficacy, membership in other community organizations, and level of education; high degree of political knowledge, commitment, and competence; proven administrative skills that translate into efficient agendas and resource delegations; skills in communication and interpersonal relations; the ability to promote equal status and encourage overall cooperation among member organizations; flexibility; and easy access to the media and decision-making centers of the community (Butterfoss et al., 1993).

Member characteristics play a major role in the synergistic purpose that compels the formation of coalitions, as well as their effectiveness. Because coalitions are made up of diverse organizations with diverse expertise and ideologies, the pooling of member assets enables the coalition to perform at an exponential rate that could not be compared to the contributions of the member organizations alone. The characteristics of members

that aid in the effectiveness of coalitions are member participation, member benefits and cost, member satisfaction, and member skills and training. Member participation is very important in that the members have to have equal say in all activities of the coalition. Members should represent a diverse sample of the community and stand as a collective representation of the community's interest as a whole. The benefits and cost of membership is an issue that can make or break coalition effectiveness. Potential benefits for the member organizations have to out weigh the potential cost. Potential benefits of coalition participation include increased networking, information sharing, and synergistic resource sharing; attaining synergistic community outcomes from the coalition's efforts; receiving membership recognition; and enhancing membership organizational capacity. Potential cost for the member organizations center around the devotion of time to the coalition taking from other organizational obligations; losing autonomy in shared decision-making and resource expenditure; lacking leadership direction; and lack of appreciation or recognition (Butterfoss, et al., 1993). In essence, member organizations will only participant efficiently in a coalition if the potential benefits outweigh the potential costs that are inherited in the coalition process. Member satisfaction is a natural extension of potential benefits versus potential costs of coalition membership. Member organizations who perceive a coalition as beneficial tend to express greater satisfaction and collaboration than member organizations who perceive coalition membership as costly. Coalitions with member organizations whom are satisfied are more cohesive, organized, and effective. Coalition satisfaction alone does not translate into membership effectiveness; members also have to possess the skills and

capacities to participate in an effective manner. If member skills and capacities are inadequate to plan, implement, and maintain coalitional activities, then training must take place to enhance coalition capacity.

Organizational climate is a variable that assesses the member groups' perception of organization characteristics. Organizational climate is characterized by the relationships among members, member-staff relationships, communication patterns among members-staff, and coalition decision-making, problem solving, and conflict resolution processes (Butterfoss et al., 1993). Relationships among member organizations, as stated earlier, are vital to the coalition's purpose and efficiency. Positive relationships among member organizations increase the likely hood of effective interventions and outcomes. In addition to inter-organizational harmony among member organizations, the interaction between coalition members and coalition staff has to be harmonious. The role of coalition staff has to be clearly defined and articulated to member organizations during the formation of the coalition. The burden of the staff is that they have to guide members into the member organizations coalitional roles and responsibilities. In addition, coalition staff members must possess an appreciation for the voluntary nature of coalitions, and have organizational and interpersonal skills to facilitate the complex, collaborative process that is inherent in coalitional organizations (Butterfoss et al., 1993). With enhanced member-staff relationships, communication patterns within the coalition can flow positively and openly. Open communication helps the coalition to maintain focus on the common purpose, objectives, and goals of the coalition. The positive communication patterns will give way to increased trust and

sharing of vital resources. With increased member-staff relationships and communication patterns remaining open and positive, decision-making, problem solving, and conflict resolution process will be greatly enhanced and efficient. The latter is achieved when the leadership/staff shares decision making with the general coalition membership. Shared decision-making leads to greater understanding, commitment, and effectiveness of coalitions (Butterfoss et al., 1993).

As discussed earlier, the internal efficiency and effectiveness of community coalitions are very vital to coalitional success, yet external coalition supports can prove to be just as vital. Coalitional external supports are vital in regard to coalitional resource exchange and community linkages. Examples of external resources include networking with elected officials, health agencies, religious organizations, civic groups, and community development associations. Partnerships outside of the coalition can be beneficial in that it can garner additional support and expertise; provide meeting space and in-kind donations; provide mailing lists and referrals; provide additional personnel; and provide additional grant funding, loans, or donations. There are four dimensions characterizing coalitional relationships with external resources. They are formalization, standardization, intensity, and reciprocity. Formalization is defined as the degree of official recognition of the relationship between the coalition and external partners. Standardization is the degree of formality of mutual procedures between the coalition and external partners. Intensity is the rate and frequency of interactions of the resources that exist between the coalition and its partners. Reciprocity is the degree of mutual exchange of resources between the coalition and its partners (Butterfoss et al., 1993).

According to Foster-Fishman, et al., (2001), all of the above factors: coalition formality, leadership characteristics, membership characteristics, organizational climate, and relationships with external supports, are essential to the framework for building collaborative capacity. Correspondently, there are four critical levels of collaborative capacity: member capacity, relational capacity, organizational capacity, and programmatic capacity. In this regard, collaborative capacity refers to the conditions needed for collaborations to effectively promote and build sustainable community outcomes and impact. These components are synonymous with the factors that contribute to coalition effectiveness and only vary slightly.

Member capacity encompasses enhancing members' core skills and knowledge; building the attitudes/motivations for collaborative capacity; and increasing access to tools for member capacity. Relational capacity encompasses the process of creating positive internal relationships and creating positive external relationships. Organizational capacity refers the ability organize members in an effective manner in regard to an effective leadership base; clear, formalized member processes and roles; clear, developed internal communication system that promotes information sharing, discussion, and resolution; effective human and financial resources; and continuous organizational training in areas related to data analysis, evaluation, seeking external expertise, and problem solving. Programmatic capacity refers to coalitional capacity to develop and implement programs that have real impact within their respective communities (Foster-Fishman, et al., 2001).

Coalition Empowerment

Coalitions and other similar collaborations were conceived as a way to enhance community capacity and empowerment (Goodman et al., 1998). This is accomplished because community coalitions provide synergistic collaborations with multiple sectors of the community in order to address community needs and solve health and welfare problems. According to Wolf (2001), effective coalitions that enhance community empowerment tend to include the following seven (7) characteristics: 1) community coalitions are holistic and comprehensive; 2) community coalitions are flexible and responsive; 3) community coalitions build a sense of communal unity; 4) community coalitions build and enhance citizen (civic) engagement in their respective communal life; 5) community coalitions provide a vehicle for community empowerment; 6) community coalitions allow diversity to be valued and celebrated as a foundation for the wholeness of the community; and 7) community coalitions are incubators for innovative community solutions for not only local conditions, but national conditions as well.

In addition to the characteristics that coalitions employ in order to enhance community capacity; they also serve as major vehicles for expanding population-based interventions; serving as the link between federal programs being implemented locally; synergizing resources in an effort to do more with less; lightens the burden of the health and human service system by aiding in the develop, implementation, and evaluation of community programs and interventions; and increasing the civic engagement necessary for our system of health and human service development to thrive under our social justice foundation (Wolff, 2001). Other ways community coalitions enhance community

capacity are that they: provide vital community training and consultations; information and referral resources; networking and coalitional development to other groups; increase grassroots communications; encourages and develops innovative programs and interventions that fosters innovative incentive grants and recognition; disseminate public information and effective social marketing; and aids in community research and evaluation (Chavis, 2001).

Effective Coalitional Outcomes

When evaluating the effectiveness of community coalitions, as well as its ultimate impact on community empowerment and community capacity, there is much anecdotal support to assure us that the constructs and variables related to coalition effectiveness are in deed effective (Fawcett et al., 1997). Yet, when searching the literature for more rigorous support in the form of objective theory and model testing of coalitional effectiveness and outcomes, the results yielded are few and far between. According to Berkowitz (2001), there is little known information about the substantive results, impact, and health outcomes produced by coalitions. Reasons cited included such items as coalitions typically have no reason to publicize their accomplishments beyond their own organizational representations and boundaries; there is no central coalition registry; and accurate documentation of all descriptions and activities of community coalitions can be rather complex. There are nine (9) methodological problems associated with the generation of empirical data accumulated in regard to community coalition outcome effectiveness. These barriers center on 1) sample

representativeness, 2) control of independent variable (coalition), 3) identification of extraneous variables, 4) control over extraneous various5) interactions among extraneous variables, 6) establishment of dependent variables, 7) measurement of dependent variables, 8) changes over time, and 9) political factors.

The first of these methodological barriers that plagues coalitional research is the fact that, in regard to sampling representation, community coalitions are not systematically well defined. When evaluating community coalitional research as a whole, community coalitions used for publishing purposes may not be representative of other community coalitions with similar purposes and goals. The second barrier centers on the treatment of a community coalition as an independent variable. From an empirical perspective, researchers do not have the operational control to determine the exact formation, structure, and processes of a coalition in a particular community. Research designs typically employed by health scientists have difficulty in finding and distinguishing between coalitional community treatments and non-coalitional community treatments in regard to a particular health outcome and/or impact. The third barrier, identification of extraneous variables, encompasses all the situations and variables that the researcher cannot operationally control for when evaluating coalition effectiveness, as well as coalition outcome effectiveness. The extraneous variables are large in number and are not uniform when comparing community coalitional activities and outcomes across communities. This leads the researcher to assess the fourth variable of control over extraneous variable; coalitional outcome cannot be controlled via extraneous variables. This makes the job of determining the attributes of community

coalitions that lead to coalition effectiveness ambiguous and non-generalizable across the spectrum of community coalitional research. The fifth barrier, centers on the interactions among extraneous variables and there synergetic impact on community coalitional outcomes. If the operational extraneous variables cannot be fully identified or controlled, there is no way to understand the various interactions these extraneous variables may form.

When establishing the dependent variables of coalitional outcome effectiveness (sixth barrier), the choice of measures to analyze (process, implementation, intervention outcomes, community impact) are not obvious. Multiple measures may be needed, yet the weighting or importance of the various measurements may not be clearly defined. As a result, the dependent variables that are prevalent within the coalition research show wide variation and choices. This makes comparisons among community coalitions very difficult; this is true not only for multi-issue community coalitions, but also for single-issue community coalitions. In regard to the seventh barrier, measurement of dependent variables, there has to be assurances that the measures obtained are representative of the coalition leadership, coalition membership, and/or the larger community. There also has to be a greater emphasis on the reliability of the answers received from the measurement. Many biases, such as social desirability and acquiescence, can cause findings to be unreliable. This is especially warranted when the coalition is seen by most as a necessity within their respective community. The eighth barrier centers on changes over time. The difficulty of coalitional outcome measurement is that the outcomes and/or impacts are not immediately visible and the noticeable results vary from coalition to coalition.

The fact that they are usually meant to have a long-term impact on the community makes multiple assessments of outcomes/impacts very desirable. Yet, taking into account, the dynamic processes of coalitional functions, many variables and outcomes tend to be operationally different at particular time periods and stages of coalitional development (Berkowitz, 2001). The ninth barrier, political factors, proves to be the most confounding obstacle in regard to the evaluation and meta-analysis of community coalitional outcomes. According to Berkowitz (2001), coalitional accomplishments may sometimes be consciously or unconsciously distorted if the coalition is receiving or seeking outside funding. There is a temptation for participants, researchers, and evaluators to respond and write reports/results to satisfy the expectations of the funding agency.

Inherent in the above barriers to the meta-analysis of coalitional outcome effectiveness is the fallacy of the evaluation process as it is applied to community coalitions. The role of evaluation in developing and sustaining community coalitions, according to Butterfoss & Francisco (2004), serve to provide:

- accountability to community representatives, stakeholders, and funding agencies
- determine whether objectives are met
- improve program implementation and impact
- increase community awareness and support
- inform policy decisions and media advocacy
- contribute to the scientific base of understanding of what types of coalitional approaches work effectively.

Evaluation of coalition effectiveness should be, at a minimum, measured at three levels: 1) processes that sustain and enhance coalition function and infrastructure; 2) programs and interventions developed to meet coalition goals, objectives, and activities; and 3) community outcomes, impacts, and changes of health status within the targeted communities. At the first level, coalition infrastructure, function, and processes are analyzed in regard to collecting and analyzing annual reports, attendance records, contribution records, meeting minutes, and surveys that measure member' levels of satisfaction, commitment, and participation. Coalition programs and interventions (level 2) should be evaluated in regard to accomplishments of specific objectives via surveys, interviews, and/or focus groups. Monitoring of program functions, successes, failure, and fidelity all encompass this level of evaluation. When evaluating level 3 (health and community change outcomes), epidemiological data has to be analyzed to assess whether the coalitional outcome(s) have had a significant impact within the targeted community. An analysis of legislative changes, social policy changes, and/or community norms and mores has to be assessed in order to evaluate whether the programs and interventions implemented have been institutionalized within the community context (Butterfoss & Francisco, 2004).

Purpose of Study

The purpose of this study was to test the operational constructs within the Community Coalition Action Theory (CCAT), mainly the constructs of 1) stages of coalition development, 2) membership engagement, 3) leadership, 4) coalition structures

& processes, as well as 5) perceived coalition ownership in explaining 6) perceived coalition capacity effectiveness (dependent variable). All of the above variables, stages of coalition development, membership engagement, leadership, coalition structures and processes, perceived coalition ownership, and perceived coalition capacity effectiveness, were combined as dimensional constructs that gave an index of the latent variable of coalition effectiveness.

As stated earlier, there is a wealth of associations and anecdotal recollections of the effectiveness of many coalitions in regard to the various constructs of the CCAT, yet there is little empirical evidence to support the associations to the constructs of CCAT and the outcome of coalition capacity effectiveness. According to Florin, Mitchell, & Stevenson (1993), The lack of systematic empirical data in regard to the strengths, weakness, needs, resources, and effectiveness leaves program planners, policy makers, and researchers in the dark as to the effectiveness and sustainability of community coalitions, as well as to what kind and what intensity of technical assistance is actually needed to enhance the capacity of community coalitions. As a result of the lack of empirical evidence in regard to coalition capacity effectiveness, there exists a gap between community coalition formation and positive health or social outcomes mediated by community coalitions. Empirical data in regard to community coalitions must be present in order to inform relevant stakeholders about the process and outcomes of community coalitions. These measurements must evaluate the diverse goals and objectives of coalitions, their various stages of development, and the dual missions of capacity building and community change (Francisco, Paine, & Fawcett, 1993).

Presently, the lack of systematic empirical research evaluating the functioning and effectiveness of community coalitions and partnerships are making it increasingly difficult to ensure coalitional success and justification for long-term funding (Granner & Sharpe, 2004).

Significance of Coalition Effectiveness Model Constructs

The following is a description of major studies that outlined operational constructs and evidence that provided the foundation of the operational constructs of The Community Coalition Action Theory that were adopted and utilized for this study. These studies in particular highlight the dynamic relationships among stages of coalition development, coalition processes and structures, leadership effectiveness, member engagement, and perceived ownership in regard to coalition capacity effectiveness and their combined effect on coalition effectiveness.

When evaluating the empirical evidence of coalition capacity effectiveness in regard to its stages of development, Florin, Mitchell, & Stevenson (1993) were the first to evaluate a coalition's training and capacity needs utilizing a developmental approach. These researchers utilized the idea of stages in coalition development to identify tasks and benchmarks that could be associated with the relevant stages in order to intervene and support the community coalition building processes at each stage. Their premise was the idea that coalitions are dynamic organizations with different task that are more or less salient at different stages of development. The framework utilized in this study closely resembles the CCAT construct of stages of coalition development. Their

framework was centered on initial mobilization, established organizational structure and functioning, building capacity for action, and planning for action, implementation, refinement, and institutionalization. Florin et al., (1993) collected data on 35 community coalitions organized to support comprehensive and community developed alcohol and other drug abuse prevention initiatives. The purpose of this particular study was to profile how well the 35 community coalitions moved through the first four developmental stages (initial mobilization; established organizational structure and functioning; building capacity for action; and planning for action).

When evaluating initial mobilization, the researchers assessed membership engagement and representation. Some noted results regarding initial mobilization were that: of the 350 active participants of the coalitions, 97% reported that they attended and participated in meetings regularly; 80% worked on tasks outside of regular meetings; and 29% served as either an officer or committee chair for their local coalition. When asked how many hours, on average, they gave to the task force each month outside of meetings, 24% responded that they gave less than 1 hour per month, 32% gave 1-2 hours a month, 22% gave 3-4 hours a month, 8% gave 5-8 hours a month, and 14% gave more than 8 hours per month (Florin et al., 1993).

The evaluation of established organizational structure within Florin et al.'s (1993) study looked at how many of the 35 community task forces had written minutes of meetings (50%); regular meeting times (71%); formulized structures and procedures with bylaws (46%); and written descriptions of the roles and responsibilities of their officers (29%). As a result, Florin et al. (1993) concluded that lack of specification of

by-laws, mission, membership and voting rights, and decision making protocols lead to confusion and conflicts that lead to identified barriers.

Within the Florin et al. (1993) framework for coalition development, building capacity for action centered on building capacity through impact of knowledge, attitudes and skills, and established linkages within the local community settings. When asked about the impact of the coalition on members' knowledge, beliefs, and skills related to community planning processes and designing and implementing prevention programs; 44% reported no change, 30% minor increase, 30% moderate increase, and 7% reported a major increase.

Further work from Florin, Mitchell, Stevenson, & Klein, (2000) utilized the developmental approach to coalition effectiveness. Within this particular study, researchers examined 35 substance abuse prevention coalitions in an effort to assess whether coalition developmental tasks predicted intermediate outcomes. Organizational climate, member skill development, and coalition linkages were used to predict key informants' (coalition leaders) ratings of coalition effects on community norms, policies, and prevention resources. Here they assessed initial mobilization according to the number of members attending coalition meetings as the average number of members attending coalition meetings within the last year. Establishing organization structure was now operationalized as Formalization via a count of 11 different dimensions of formalized rules and procedures. Building capacity for action centered on perceived knowledge and skill development. This construct was operationalized via a 7-item scale (a= .84) in which members rated the extent to which participation had increased their

knowledge, beliefs, and skills (1 = no change, 4 = major increase). Individual scores were aggregated into a single score for each coalition. Inter-organizational linkages of the coalition were also assessed according to the leader's report of the extent of coalition contact during the past twelve months with various community constituencies.

In regard to Implementation, Florin et al., 2000, assessed the impact of input resources, mobilization, and capacity building. Implementation effects were captured via a 5-item scale (a= .87) in which coalition leaders rated the effects of the coalitions visibility, acceptability, and perceived impact among its priority population and community. When analyzing the implementation effect, perceived member knowledge and skill development ($r = .50$, $p < .01$)) and inter-organizational linkages ($r = .48$, $p < .01$) were highly correlated to implementation effectiveness. Through the analysis of hierarchic multiple regression to predict successful implementation, both membership knowledge and skills, and organizational linkages contributed significantly to the prediction of implementation success, with a multiple R of .63 and an adjusted R^2 of .33 ($p < .002$). Yet, the variables membership knowledge and skills, and organizational linkages had no significant relationship with the quality of coalition action plans. The only variables predicting the quality of coalition action plans were number of paid staff hours ($r = .35$, $p < .05$) and member attendance of meetings ($r = .41$, $p < .05$). The researchers concluded that although membership knowledge and skills, and organizational linkages increased the effectiveness of coalition implementation; development and quality of the action plan being implemented might depend more on

technical assistance and professional skills rather than the overall climate of the coalition and participation of coalition members.

When assessing the capacity for coalition effectiveness in regard to the relationship between coalition structure and coalition impact; the study by Hays, et al., 2000, test the hypothesis that coalitions' organizational and structural characteristics are related to their members' perceived effectiveness in strengthening delivery of community-wide prevention services, and their ability to develop high-quality comprehensive, outcome-based prevention plans. They operationalized the coalition impact via a 7-item (a = .91) scale assessing coalition members perception of the changes their coalition has made to their community's prevention system. Among the independent variables were leadership effectiveness and membership participation. Leadership effectiveness was derived from a 6-item scale (a = .92) assessing members' perceptions of the extent to which the coalition leader directs the group toward collaborative goal achievement. Membership participation was measured via 10-item scale (a = .87) assessing members' perception of the participation, input, and cohesiveness of the coalitions' membership. The results of this study indicated that leadership effectiveness and member participation were significantly related to coalitional capacity and organizational effectiveness. Researchers concluded that coalitions should continually build upon their organizational strengths and weaknesses and develop strategic plans to enhance its organizational capacity.

A study by Butterfoss et al., 1996, further operationalized membership engagement by examining whether key characteristics of coalitions are related to

coalition effectiveness as measured by member satisfaction, commitment to the coalition, and the quality of planning efforts. This study utilized seven multi-item scales with independent variables being leadership roles, staff-committee relations, organizational climate, decision-making influence, and community linkages; with committee satisfaction and quality of action plan as the dependent variables. The researchers received responses from 190 members representing 20 committees within a State coalition. They evaluated both group-level effectiveness (committees) as well as individual-level effectiveness (individual members). Results of the regression analysis showed that committee satisfaction was explained by leadership effectiveness, greater influence in decision-making, and greater cohesion among members with 45% (adjusted R^2) of the variance accounted for. Conclusions from this study supported the premise that competent leadership, shared decision making, linkages with other organizations, and a supportive environment are key elements of the identification of coalition capacity effectiveness and lead to decreased perceived cost and increased perceived benefits of participation (Butterfoss et al., 1996).

The work of Butterfoss et al., 1996 was further developed by Kegler et al., 1998. These authors utilized modified assessment tools from Butterfoss et al., 1996 and analyzed, at the coalition level, factors related to member participation, satisfaction, quality of action plan, resource mobilization, and implementation. This study utilized 10 coalitions (273 members) that were part of a statewide program. Researchers utilized leadership, decision making, communication, conflict, benefits and cost of participation, organizational climate, staffing, capacity building, member profile, recruitment patterns,

organizational structure, and community capacity as independent variables. Coalition Effectiveness was measured via member participation, member satisfaction, quality of action plan, resource mobilization, and implementation. Significant correlates of the dependent variable of member participation were communication (r = .70) and member profile (r = .70). Significant correlates of the dependent variable of member satisfaction were leadership effectiveness (r = .78), staff skill (r =.82), communication (r = .73), organizational climate (r = .65), and capacity building (r =.61). Significant correlates of the dependent variable of action plan quality were member profile (r = -.55) and staff time (r = .56). Significant correlates of the dependent variable resource mobilization were staff time (r = .78) and organizational structure (r = .66). The information the authors presented throughout the study was complimentary to Butterfoss et. al, 1996 in support of the premise that coalitional capacity effectiveness and implementation are closely related to membership engagement and capacity, where as the quality of action plans developed depend more on staff (professional) skills. It is possible that membership satisfaction and participation may not lead to improved health outcomes via effective action plans. Although member satisfaction and participation are in themselves predictive of coalition effectiveness, they do not necessarily correlate with coalition organizational capacity, which builds the skills necessary to plan quality action plans and implement them properly.

References to perceived coalition ownership were first detailed by Israel, Checkoway, & Zimmerman, 1994; and were conceptualized via community empowerment. Utilizing the concept of community empowerment, Israel et al, 1994,

characterized ownership by the following elements: 1) personal efficacy and competence, 2) a sense of mastery and control, and 3) a process of participation to influence institutions and decisions. A 12-item scale (a=.71) measuring ownership in the form of perceived control measured levels of empowerment at the individual (2-items), organizational (5-items), and community level (5-items). This scale was created in order to gather data on individuals' perceptions of influence and control within a community or communities. Evidence of the outcomes from pilot testing of the instrument was not reported. Yet authors stated anecdotal relationships with increased organizational and coalitional effectiveness as they relate to community empowerment. Implications given by the authors recommenced that the instrument be measured in the context of a community empowerment intervention, along with other assessment methods, and to refine scales as appropriate (Israel, et al., 1994).

As the above shows, there are a multitude of operational constructs and variables that set out to measure the elusive question of what makes a coalition effective. The theory and framework, which guides the following research, the Community Coalition Action Theory (CCAT), was created to combine, synergize, and operationalize the various ideas and concepts related to coalition effectiveness into one consistent framework. Since its introduction to the main press (2002), there has been a galvanization of coalition assessment tools and evaluative methods. Much of the research that forms the basis of the CCAT was conducted in the 1990s. These early studies tended to focus on coalition functioning and intermediate indicators of effectiveness, such as satisfaction, participation, action plan quality, and implementation

(Butterfoss & Keglar, 2002). Thus the constructs that form the Community Coalition Action Theory where informed by empirical research, such as those studies outlined previously. Yet, there has only been assumptions and anecdotal evidence in regard to how they interrelate with each other. According to Butterfoss & Keglar (2002), the order of the constructs and the propositions that underline them are in deed logical and are premised on reciprocal or directional linkages. Yet, the applied research does not totally confirm that the assumptions are correct. The authors of the CCAT further state that there is little research in the area of weighing each variable within the model to see what is the level of importance in regard to coalition effectiveness, i.e. coalition processes or membership engagement. The following study intends to clarify and answers some of the assumptions surrounding the Community Coalition Action Theory constructs and their strength of association with coalition capacity and ultimately, coalition effectiveness within a controlled community coalition.

METHODS

Hypothesis

Null Hypothesis: There is No significant correlation/relationship between the independent variables, Stages of Coalition Development; Leadership Effectiveness; Coalition Structures and Processes; Membership Engagement; and Perceived Coalition Ownership, when predicting Perceived Coalition Capacity Effectiveness (dependent variable).

Research Hypothesis: The independent variables, Stages of Coalition Development; Leadership Effectiveness; Coalition Structures and Processes; Membership Engagement; and Perceived Coalition Ownership will significantly explain and predict high levels of Perceived Coalition Capacity Effectiveness (dependent variable).

Research Question One: Of the various items that make up the latent variables of Stages of Coalition Development; Leadership Effectiveness; Coalition Structures and Processes; Membership Engagement; Perceived Coalition Ownership; and Perceived Coalition Capacity Effectiveness, what are the strengths and area for improvement in regard to the Cancer Connection program?

Research Question Two: Of the regional Cancer Councils that make up the membership of Cancer Connection, which ones exhibit the highest level of Coalition Effectiveness in regard to Stages of Coalition Development; Leadership Effectiveness; Coalition

Structures and Processes; Membership Engagement; Perceived Coalition Ownership; and Perceived Coalition Capacity Effectiveness?

Research Question Three: Of the variables Stages of Coalition Development; Leadership Effectiveness; Coalition Structures and Processes; Membership Engagement; and Perceived Coalition Ownership, which combination best explains the outcome of Perceived Coalition Capacity Effectiveness?

Coalitional Structure (Cancer Connection Program)

Overall, Arkansans are at greater risk of developing and dying from cancers of the lung, head and neck, breast and prostate than most Americans. Unhealthy behaviors, limited access to health care and a large subpopulation associated with increased risk of developing cancer. An estimated 14,950 new cancer cases and 6,210 cancer deaths will occur in Arkansas in 2005. Arkansas ranks 12th highest in cancer mortality rates.

The mission of the University of Arkansas for Medical Sciences, Arkansas Cancer Research Center's Cancer Connection program is to reduce cancer incidence and mortality in Arkansas through the development and implementation of locally designed and culturally appropriate intervention strategies. Cancer Connection emphasizes community participation, coalition building, assessment, and the development and implementation of cancer control strategies that are designed by and for local communities. Cancer Connection provides communities with the tools and technical assistance they need to develop practical solutions to their unique cancer problems. The

Cancer Connection program at the University of Arkansas for Medical Sciences, Arkansas Cancer Research Center provides leadership and coordination, and collaborates with several community organizations in an effort to:

1. Recruit and mobilize community members to participate in Cancer Connection planning processes
2. Assess problems, needs, and resources in their local community
3. Develop action plans that include intervention strategies that fit each community's unique needs
4. Implement the action plans
5. Evaluate the program's progress
6. Replicate Cancer Connection in counties as funding becomes available

Currently there are nine counties involved with Cancer Connection initiatives. These counties have community coalitions in the form of local Cancer Councils whom are actively engaged in the process of developing and implementing cancer control awareness projects and events. These Cancer Councils are composed of local residents representing all sectors of their respective communities. They are coordinated at the local level by a volunteer Cancer Council chair and co-chair. Through UAMS/ACRC Cancer Connection, UAMS/ACRC provides leadership and coordination; and provides the various communities with the tools and technical assistance needed to develop solutions that are unique to their respective cancer disparities and burdens. These individual councils are in themselves coalitions that come together to form the Cancer

Connection Program. Cancer Councils are coalitions at the local level whose job are to oversee the three-step process of assessing, planning, and implementing appropriate cancer control intervention strategies for its counties. The counties that make up the various Cancer Councils are Bradley, Cleveland, Cross, Grant\Jefferson, Marion, Mississippi, Newton, Phillips, and St. Francis counties. Their charge is to identify cancer-related problems in their local community; establish local cancer control priorities; identify and fill gaps in local service and delivery; develop improved communication with local health care providers; and develop intervention strategies that fit their respective community's unique needs. For the purpose of this study, only five Cancer Councils are represented. Newton and Grant/Jefferson Cancer Council members were excluded based on the criteria that all participating Cancer Councils must have been affiliated with the Cancer Connection Program for at least 12 months. This criterion was based in part because the Cancer Councils chosen were classified within the maintenance Stage of Coalition Development and those Cancer Councils with less than 12 months participation were classified within the formative Stage of Coalition Development. Qualification for coalition maintenance was granted due to the Cancer Councils' ability to sustain membership engagement and assess, plan, select, implement, and refine Cancer Council strategies.

Research Design

Study Population

The priority population for this study was the members and participants of the Cancer Connection program. Each of the seven Cancer Councils had approximately 12 members for a total of eight-four (N=84) participants. These participants represent members whom belong to local health agencies, local governments, local faith-based institutions, and local voluntary health organizations, as well as lay citizens whom are interested in cancer control and prevention. Each of the seven Cancer Councils is lead by a chair and co-chair. These chairs and co-chairs have regular contact with representatives from the lead agency (ACRC/Caner Connection) and have been active for at least twelve (12) months. The results presented represent 51 of 86 (59%) participants of the University of Arkansas for Medical Sciences, Arkansas Cancer Research Center's Cancer Connection Program. Due to scheduling conflicts and changing of leadership, Phillips and Marion Cancer Councils were unable to actively participate. Originally, Phillips and Marion council members were aggressively targeted.

Data Collection

Data Collection took place during local Cancer Council meetings scheduled during an 8-week period. Members voluntarily completed the survey. The survey took approximately took approximately 10 to 20 minutes to complete. After completion of the survey, participants were given a $20 dollar gift certificate for their effort and

support. Completion of the survey was not mandatory and did not affect member status within the Cancer Connection program. There was no personally identifying information asked linking the participant to the study. The survey protocol was administered by the Principle Investigator (myself) via the Cancer Connection Program Assessment Proctor (Appendix A).

Instrumentation

This pencil and paper survey consisted of approximately 101 items that asked questions related to General Questions (n=28); Structures and Processes [Coalition Structures & Processes] (n=10); Membership Engagement [Coalition Membership Engagement] (n=10); Leadership Effectiveness [Coalition Leadership Effectiveness] (n=15); Development [Stages of Coalition Development] (n=15); Ownership [Perceived Coalition Ownership] (n=8); and Effectiveness [Perceived Coalition Capacity Effectiveness] (n=15) (Appendix B). Face validity of the survey items and constructs were evaluated under a two-tier system. Tier 1 consisted of the evaluation of the newly constructed Caner Connection Program Assessment (CCPA) by the research team at the University of Arkansas for Medical Sciences, Arkansas Cancer Research Center, Cancer Control Outreach Center. This team consisted of two Professors, one Associate Professor, the program director of Cancer Connection, and the Principle Investigator (myself). After consensus related to content importance, readability, and understandability of each item via the Research Team, each local Cancer Council chair was informally interviewed (tier 2). Input was solicited from nine (N=9) Cancer Council

chairs in regard to content importance, readability, and understandability of the CCPA and how it directly applied to their local situations. After the modifications and improvements of the CCPA, as suggested by Cancer Council chairs, the Cancer Connection Program Assessment was finalized.

Coalition structures and processes centered on the Cancer Councils' written objectives, communications/ decision-making procedures, resource allocation, meeting structures, and priorities. Coalition membership engagement consisted of shared mission and understanding of individual roles, active membership participation in planning, implementing, and evaluating cancer activities, and level of participation and accomplishment. Coalition leadership effectiveness consisted of members' perceptions of the leaders influence in collaborative group achievement, group/incentive management, defined roles, meeting organization, and conflict resolution. Stages of coalition development consisted of indices that captures where the various Cancer Councils were within their stage of development in regard to 1) formation, 2) implementation, 3) maintenance, or 4) or institutionalization of cancer control programs, initiatives, and influences.

The measurements of the experimental latent variables Coalition Structures and Processes, Membership Engagement, Leadership Effectiveness, and Stages of Coalition Development were captured through a four-point Likert-type scale for level of agreement (1=completely disagree, 2=disagree, 3=agree, or 4=completely agree) with a given statement. All of the above scales were adapted and modified versions of questionnaires described and developed by Goldstein (1997), Butterfoss et al. (1996),

Butterfoss (1998), and Kegler et al. (1998) (Appendix C). Internal reliability analysis via Cronbach's Alpha was evaluated for each scale.

Perceived coalition ownership consisted of the cancer councils' perceived influence and control over coalition external influences within the community, as well as its internal influence on its members. The measurement of the latent variable, Perceived Coalition Ownership was captured through a four-point Likert-type scale for level of agreement (1=completely disagree, 2=disagree, 3=agree, or 4=completely agree) with a given statement. This scale was an adaptation and modification of Israel et al. (1994) Perceived Control Scale Items: Multiple Levels of Empowerment Indices questionnaire (Appendix D). Internal reliability analysis via Cronbach's Alpha was evaluated for this scale.

Perceived Coalition Capacity Effectiveness was captured through a four-point Likert-type scale for level of impact (1=no impact, 2=low impact, 3=medium impact, or 4=high impact) in regard to statements about the effect the Cancer Council has had on individual capacity and efficacy. Perceived Coalition Capacity Effectiveness consisted of the Cancer Council members' capacity in regard to understanding and conducting needs/assets assessments, designing and implementing cancer control activities, ability to communicate effectively, ability to evaluate progress, and knowledge of cancer related resources available within their respective communities. This scale was adapted and modified from Taylor-Powel (1998) Impact of Group on Members Scale within the Community Group Member Survey (Appendix E). Internal reliability analysis via Cronbach's Alpha was evaluated for this scale.

Statistical Analysis.

Descriptive analyses were employed in order to analyze each item of the survey and obtain frequencies, means, statistical distributions, etc. Correlations among the experimental variables were analyzed using Pearson product-moment correlation coefficients utilizing the individual Cancer Council members (n=51) to evaluate and capture the relationships among the study variables in the context of the overall Cancer Connection program. The significance of the Pearson correlation of the independent variables of Structures and Processes; Membership Engagement; Leadership; Development; and Ownership were utilized to form the basis of multiple regression analysis in order to explain Effectiveness. Multiple regression analysis was employed to test whether the independent variables Structures and Processes; Membership Engagement; Leadership; Development; and Ownership significantly explained and predicted high levels of Effectiveness. Stepwise regression was employed in order to identify the best two, three, four, and five variable regression models that best explained and predicted Effectiveness. These analyses were preformed at the Cancer Connection (individual) level (n=51). Because of the exploratory nature of this study, correlations with p values $< .05$ were considered statistically significant.

Regression Analysis was accomplished by computing the sum of the means for each item within the independent and dependent latent variables. The resulting scores were: Development (15 – 60pts); Effectiveness (15 – 60pts); Structures and Processes (10 – 40pts); Membership Engagement (10 – 40pts); Ownership (8 – 32pts); and Effectiveness (15 – 60pts). The above point systems were developed according to

assigned points given per response (completely disagree = 1; disagree = 2; agree= 3; and completely agree = 4 and no impact = 1; low impact = 2 ; medium impact = 3; and high impact = 4). Each item in each construct was added up to report an aggregate score for the construct variables. In addition, each aggregate score for the constructs of Structures and Processes, Membership Engagement, Leadership, Development, Ownership, and Effectiveness was computed to operationalize an overall Coalition Effectiveness Index score (73 – 292).

RESULTS

Membership Demographics

The number of Cancer Connection program participants whom completed the Caner Connection Program Assessment (CCPA) were fifty-one (n=51) of eighty-six (N=86) participants representing five of the seven active Cancer Councils. The Cancer Council members represented were Mississippi (29%), Cleveland (24%), Bradley (21%), Cross (18%), and St. Francis (8%). The ages of these participants ranged from under 30 (8%), 30 to 44 (29%), 45 to 64 (53%), and 65 or older (10%). Of the participants in this study, 69% were female and 31% were male. Education levels achieved among participants were high school/GED (18%), some college (19%), college graduate (45%), graduate school (16%), and postgraduate school (2%). Race/ethnic categories that participants most identified with were white (69%), black (29%), and Hispanic (2%).

The level of function and purpose of the Cancer Connection program and the participants roles and understanding were of the impression that Cancer Council: Members interact primarily for the purpose of exchanging information and communication (2%), Members provide helpful resources to support each other's interests and goals; there is some joint planning and activity, but resources are separate (20%), Members work together on goals that are complementary; there is coordination and some sharing of resources (23%), Members share (or are working toward) a common vision that links diverse interests; actions are jointly created and resources, authority, and decision making are controlled in the group (55%). Participants primarily

represented organizations in the area of business (8%), law/ legislative/ judicial (8%), health/ medical (21%), education (16%), individual citizen group (15%), faith based/ religious (2%), social service (public/ private non-profit) (22%), and other (8%).

Length of participation by Cancer Council members consisted of service for less than 12 months (23%), 12 to 23 months (21%), 24 to 35 (28%), and 36 to 48 months (28%). In regard to participant activity in the area of regular meeting attendance, 90% had attended meetings within the past six months, where as 61% have attended meetings regularly beyond six months. Active communication per participant in regard to making comments, expressing ideas, etc. within the past six months were 84%, with 55% stating active communication during meetings prior to the past six months. Fifty-eight percent of members reported that they have served as part of an activity committee within the past six months; whereas 42% members reported participation on an activity committee prior to the past six months. Activity and time dedicated to the Cancer Council outside of meetings were performed by 56% of participants within the past six months, conversely, only 40% reported outside activity being performed prior to the past six months.

Participation of organizing Cancer Council events outside of meetings were performed by 55% of the membership within the past six months, whereas 40% reported organizing Cancer Council events prior to the past six months. Fifty-five percent of participants reported that they directed the implementation of a particular Cancer Council program/ activity within the past six months, whereas 41% directed the implementation of particular programs/ activities prior to the past six months.

Structures and Processes

The latent independent construct of Structures & Processes consisted of a 10-item scale that yielded a significant Cronbach's Alpha of $\alpha = .9339$. Overall, aggregate participants score index for Structures & Processes was 32.10 out of a total of 40 (80%) possible points. Overall mean indices reported per item in regard to Structures & Processes were that the Cancer Councils have clear mission statements in writing ($\mu = 3.14$), clear goals and objectives ($\mu = 3.18$), regular, structured meetings ($\mu = 3.57$), effective communication protocols ($\mu = 3.31$), organized mechanism to make decisions ($\mu = 3.22$), mechanism to solve problems ($\mu = 3.14$), allocates resources fairly ($\mu = 3.33$), assures that members complete assignments in timely manner ($\mu = 3.16$), orients new members to Cancer Council's functioning and purpose ($\mu = 3.04$) and regularly trains new and old members about cancer initiatives ($\mu = 3.02$). The level of agreement per Structures & Processes item response is displayed in the following (Figure 2):

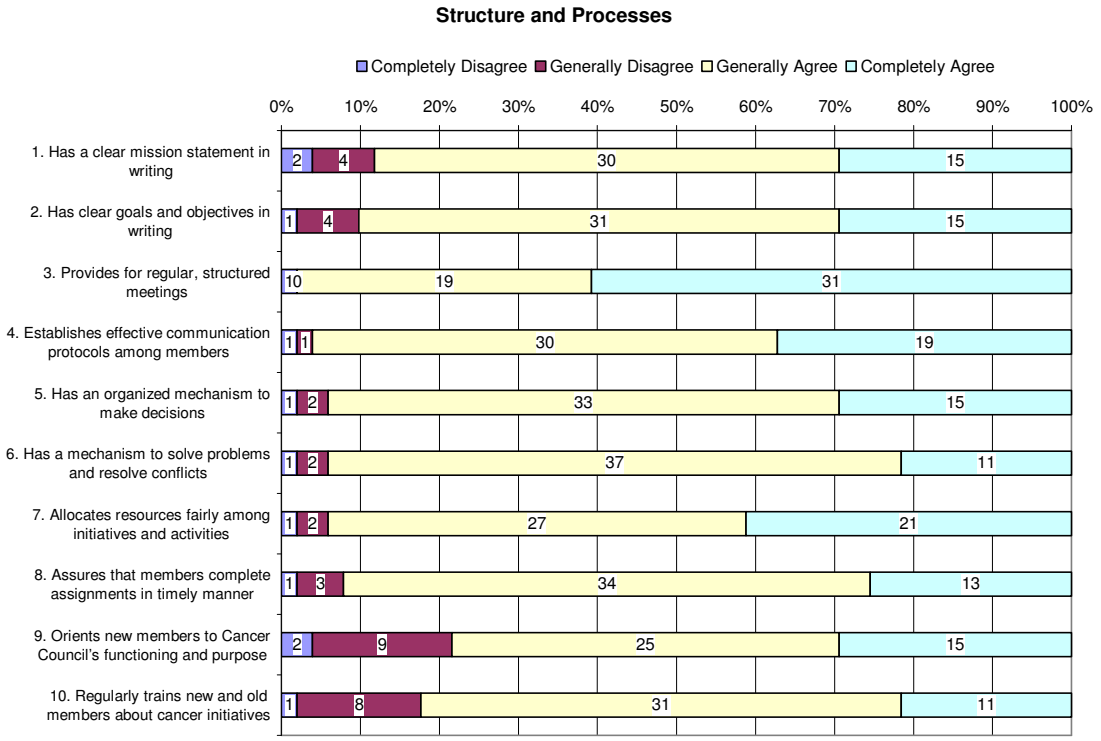


Figure 2: Structures and Processes Scale of Agreement Distribution

When evaluating the results of the Cancer Connection program Structures & Processes construct by individual Cancer Councils, score indices ranged from 34.22 (Cross), 34.00 (Bradley), 31.60 (Mississippi), 30.33 (Cleveland), and 29.25 (St. Francis) respectively. Mean scores per item varied greatly from among local Cancer Councils in regard to their performance on individual item mean. The following (Table 1) gives a description of all relative means and their impact on Structures & Processes score indices for each local Cancer Council.

Table 1: Cancer Connection Program Assessment Structures and Processes Mean Scores

CCPA Structures and Processes

	Total N=51	Cleveland n=12	Cross n=9	Bradley n=11	St. Francis n=4	Mississippi n=15
1. Has a clear mission statement in writing	3.14	2.67	3.44	3.36	2.50	3.33
2. Has clear goals and objectives in writing	3.18	2.83	3.33	3.45	3.00	3.20
3. Provides for regular, structured meetings	3.57	3.33	3.78	3.64	3.25	3.67
4. Establishes effective communication protocols among members	3.31	3.17	3.67	3.55	2.75	3.20
5. Has an organized mechanism to make decisions	3.22	3.00	3.22	3.55	3.00	3.20
6. Has a mechanism to solve problems and resolve conflicts	3.14	3.00	3.11	3.36	3.00	3.13
7. Allocates resources fairly among initiatives and activities	3.33	3.33	3.44	3.45	3.00	3.27
8. Assures that members complete assignments in timely manner	3.16	3.17	3.33	3.27	3.00	3.00
9. Orients new members to Cancer Council's functioning and purpose	3.04	2.92	3.44	3.27	2.75	2.80
10. Regularly trains new and old members about cancer initiatives	3.02	2.92	3.44	3.09	3.00	2.80
Structures and Processes	**32.10**	**30.33**	**34.22**	**34.00**	**29.25**	**31.60**
Cronbach's Alpha	0.9339					

Membership Engagement

The latent independent construct of Membership Engagement consisted of a 10-item scale that yielded a significant Cronbach's Alpha of $\alpha = .9047$. Overall, aggregate participants score index for Membership Engagement was 32.59 out of a total of 40 (82%) possible points. Overall mean indices reported per item in regard to Membership Engagement was that they: share the mission of the Cancer Council ($\mu = 3.39$), offer a variety of individual resources and skills ($\mu = 3.35$), clearly understand their individual roles ($\mu = 3.18$), actively plan, implement, and evaluate cancer initiatives and activities ($\mu = 3.25$), assume lead responsibility for Cancer Council tasks ($\mu = 3.10$), share workload equitably ($\mu = 3.10$), regularly participate in meetings and cancer initiatives and activities ($\mu = 3.39$), feel sense of accomplishment ($\mu = 3.41$), and seek out training opportunities in areas related to Cancer Council activities ($\mu = 3.10$). The level of agreement per item of the Membership Engagement construct is displayed in the following (Figure 3):

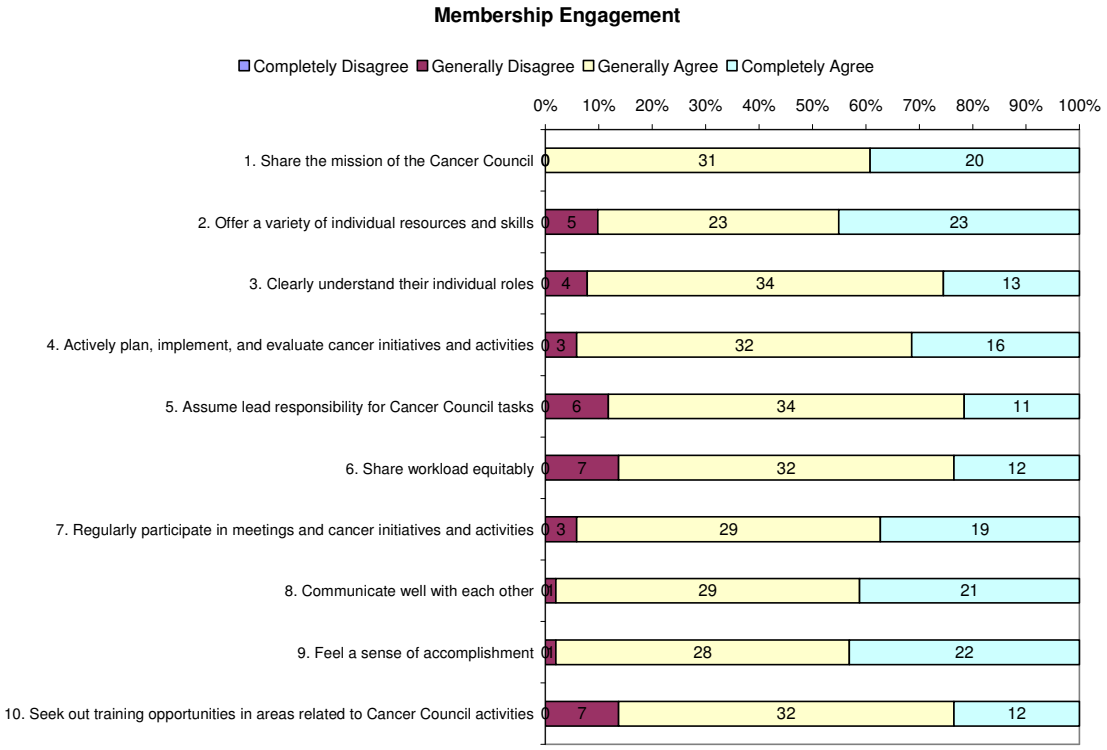


Figure 3: Membership Engagement Scale of Agreement Distribution

When evaluating the results of the Cancer Connection program Membership Engagement construct by individual Cancer Councils, score indices ranged from 33.89 (Cross), 33.55 (Bradley), 32.42 (Cleveland), 31.67 (Mississippi), and 31.00 (St. Francis) respectively. Mean scores per item varied greatly from among local Cancer Councils in regard to their performance on individual item mean. The following (Table 2) gives a description of all relative means and their impact on Membership Engagement score indices for each local Cancer Council.

Table 2: Cancer Connection Program Assessment Membership Engagement Mean Scores

CCPA Membership Engagement

	Total N=51	Cleveland n=12	Cross n=9	Bradley n=11	St. Francis n=4	Mississippi n=15
1. Share the mission of the Cancer Council	3.39	3.17	3.56	3.45	3.50	3.40
2. Offer a variety of individual resources and skills	3.35	3.50	3.44	3.36	3.00	3.27
3. Clearly understand their individual roles	3.18	3.08	3.33	3.27	3.00	3.13
4. Actively plan, implement, and evaluate cancer initiatives and activities	3.25	3.25	3.44	3.27	3.25	3.13
5. Assume lead responsibility for Cancer Council tasks	3.10	2.92	3.33	3.09	3.25	3.07
6. Share workload equitably	3.10	3.17	3.00	3.18	3.25	3.00
7. Regularly participate in meetings and cancer initiatives and activities	3.31	3.42	3.44	3.45	2.75	3.20
8. Communicate well with each other	3.39	3.33	3.67	3.55	3.00	3.27
9. Feel a sense of accomplishment	3.41	3.33	3.67	3.55	3.00	3.33
10. Seek out training opportunities in areas related to Cancer Council activities	3.10	3.25	3.00	3.36	3.00	2.87
Membership Engagement	**32.59**	**32.42**	**33.89**	**33.55**	**31.00**	**31.67**
Cronbach's Alpha	0.9047					

Leadership

The latent independent construct of Leadership consisted of a 15-item scale that yielded a significant Cronbach's Alpha of $\alpha = .9489$. Overall, aggregate participants score index for Leadership was 50.53 out of a total of 60 (82%) possible points. Overall mean indices reported per item in regard to Leadership were that they: were committed to the mission of the Cancer Council ($\mu = 3.53$), provide leadership and guidance in maintaining the Cancer Council ($\mu = 3.39$), have appropriate time to devote to Cancer Council activities ($\mu = 3.24$), plan effectively and efficiently ($\mu = 3.29$), knowledgeable about cancer initiatives and collaborations ($\mu = 3.33$), flexible in accepting different viewpoints ($\mu = 3.45$), promote equity and collaboration among members ($\mu = 3.29$), proficient in organizational and communication skills ($\mu = 3.31$), value member's input ($\mu = 3.49$), recognize members for their unique contributions ($\mu = 3.41$), competent in negotiating, solving problems, and resolving conflicts ($\mu = 3.39$), attentive to individual member concerns ($\mu = 3.43$), effective in managing meetings ($\mu = 3.43$), proficient in gathering external resources ($\mu = 3.31$), and work within influential political and community networks ($\mu = 3.31$). The level of agreement per item of the Leadership construct is displayed in the following (Figure 4):

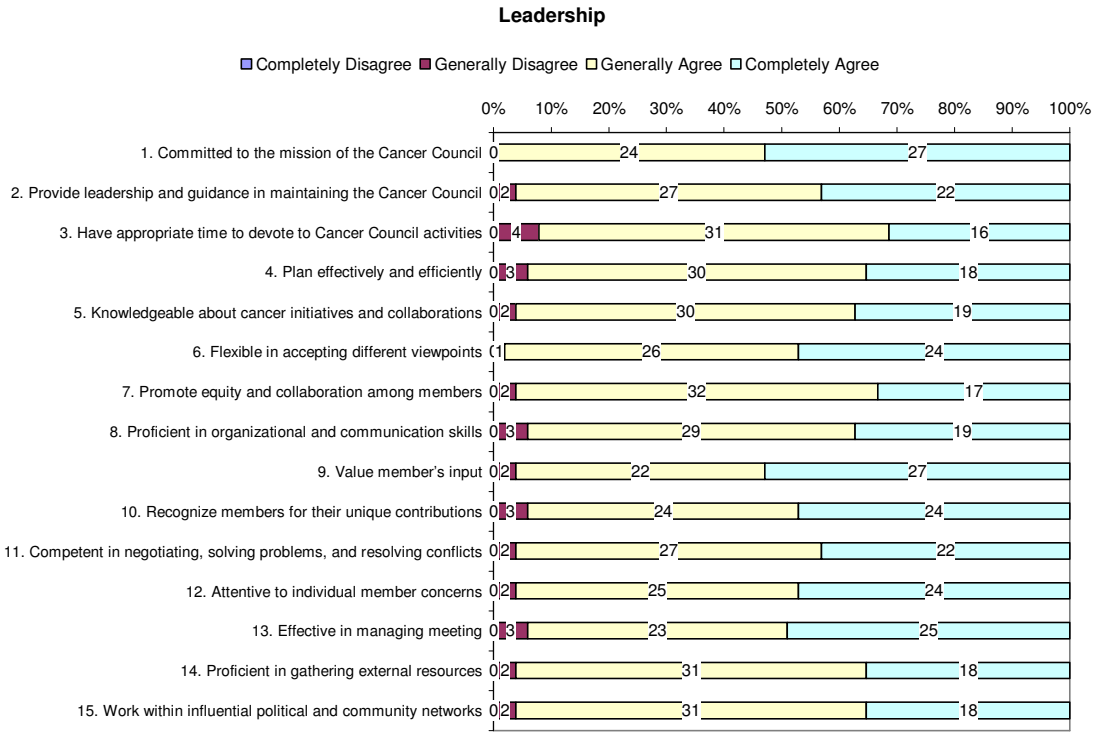


Figure 4: Leadership Scale of Agreement Distribution

When evaluating the results of the Cancer Connection program Leadership construct by individual Cancer Councils, score indices ranged from 52.89 (Cross), 51.83 (Cleveland), 51.00 (Bradley), 49.40 (Mississippi), and 45.50 (St. Francis) respectively. Mean scores per item varied greatly from among local Cancer Councils in regard to their performance on individual item mean. The following (Table 3) gives a description of all relative means and their impact on Leadership score indices for each local Cancer Council.

Table 3: Cancer Connection Program Assessment Leadership Mean Scores

CCPA Leadership

	Total N=51	Cleveland n=12	Cross n=9	Bradley n=11	St. Francis n=4	Mississippi n=15
1. Committed to the mission of the Cancer Council	3.53	3.42	3.56	3.55	3.50	3.60
2. Provide leadership and guidance in maintaining the Cancer Council	3.39	3.50	3.44	3.45	3.00	3.33
3. Have appropriate time to devote to Cancer Council activities	3.24	3.17	3.67	3.27	3.00	3.07
4. Plan effectively and efficiently	3.29	3.42	3.44	3.36	2.75	3.20
5. Knowledgeable about cancer initiatives and collaborations	3.33	3.33	3.56	3.45	3.25	3.13
6. Flexible in accepting different viewpoints	3.45	3.42	3.56	3.36	3.25	3.53
7. Promote equity and collaboration among members	3.29	3.33	3.33	3.27	3.00	3.33
8. Proficient in organizational and communication skills	3.31	3.42	3.44	3.45	3.00	3.13
9. Value member's input	3.49	3.67	3.78	3.36	3.25	3.33
10. Recognize members for their unique contributions	3.41	3.67	3.56	3.36	3.25	3.20
11. Competent in negotiating, solving problems, and resolving conflicts	3.39	3.50	3.56	3.36	3.25	3.27
12. Attentive to individual member concerns	3.43	3.50	3.67	3.36	3.00	3.40
13. Effective in managing meeting	3.43	3.58	3.56	3.45	2.75	3.40
14. Proficient in gathering external resources	3.31	3.42	3.44	3.45	2.75	3.20
15. Work within influential political and community networks	3.31	3.50	3.33	3.45	2.50	3.27
Leadership	**50.63**	**51.83**	**52.89**	**51.00**	**45.50**	**49.40**
Cronbach's Alpha	0.9489					

Development

The latent independent construct of Development consisted of a 15-item scale that yielded a significant Cronbach's Alpha of $\alpha = .9201$. Overall, aggregate participants score index for Development was 47.70 out of a total of 60 (80%) possible points. Overall mean indices reported per item in regard to Development were that: leadership positions are clearly designed ($\mu = 3.31$), local needs assessments have been conducted ($\mu = 3.18$), action plans for implementation of cancer related activities are developed ($\mu = 3.20$), action plans are implemented as planned ($\mu = 3.22$), action plans are revised as necessary ($\mu = 3.22$), financial and material resources are secured ($\mu = 3.20$), cancer council is broadly recognized as authority on issues related to cancer ($\mu = 3.00$), membership benefits outweigh the cost of membership ($\mu = 3.27$), Cancer Council accomplishments are shared with community members ($\mu = 3.29$), Cancer Council is included in other external community collaborative efforts ($\mu = 3.24$), Cancer Council has influence over local, state, and private health agency initiatives ($\mu = 2.98$), Cancer Council activities have been adopted by other health agencies or institutions ($\mu = 3.04$), funding has been obtained to support Cancer Council activities ($\mu = 3.16$), the mission of your Cancer Council is constantly refined ($\mu = 3.10$), membership includes broad-based participation from community leaders, professionals, and grass-roots organizers representing targeted population ($\mu = 3.29$). The level of agreement per item of the Development construct is displayed in the following (Figure 5):

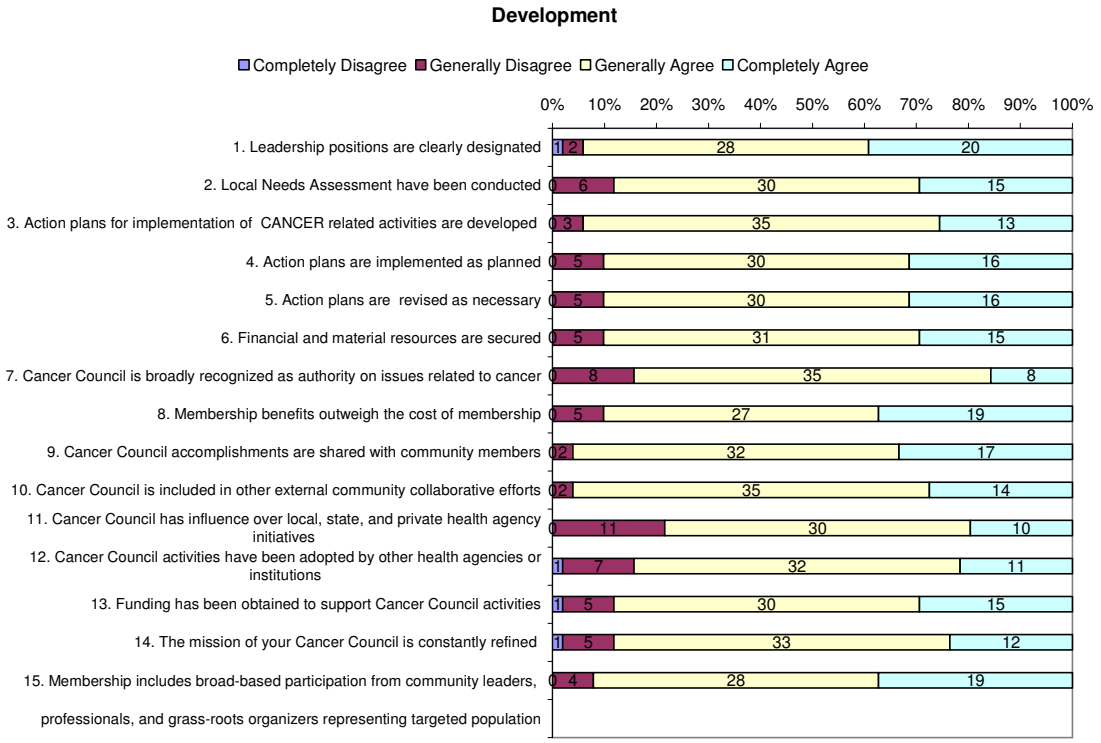


Figure 5: Development Scale of Agreement Distribution

When evaluating the results of the Cancer Connection program Development construct by individual Cancer Councils, score indices ranged from 51.51 (Bradley), 49.52 (Cross), 48.10 (Cleveland), 44.99 (Mississippi), and 41.75 (St. Francis) respectively. Mean scores per item varied greatly among local Cancer Councils in regard to their performance on individual item means. The following (Table 4) gives a description of all relative means and their impact on Development score indices for each local Cancer Council.

Table 4: Cancer Connection Program Assessment Stage of Development Mean Scores

CCPA Stage of Development

	Total N=51	Cleveland n=12	Cross n=9	Bradley n=11	St. Francis n=4	Mississippi n=15
1. Leadership positions are clearly designated	3.31	3.17	3.44	3.64	2.75	3.27
2. Local Needs Assessment have been conducted	3.18	3.67	3.11	3.36	3.00	2.73
3. Action plans for implementation of CANCER related activities are developed	3.20	3.17	3.33	3.45	3.25	2.93
4. Action plans are implemented as planned	3.22	3.17	3.44	3.55	3.00	2.93
5. Action plans are revised as necessary	3.22	3.25	3.33	3.55	3.00	2.93
6. Financial and material resources are secured	3.20	3.17	3.67	3.36	3.00	2.87
7. Cancer Council is broadly recognized as authority on issues related to cancer	3.00	3.08	3.00	3.27	2.50	2.87
8. Membership benefits outweigh the cost of membership	3.27	3.50	3.22	3.45	2.75	3.13
9. Cancer Council accomplishments are shared with community members	3.29	3.42	3.22	3.45	3.00	3.20
10. Cancer Council is included in other external community collaborative efforts	3.24	3.33	3.33	3.45	2.75	3.07
11. Cancer Council has influence over local, state, and private health agency initiatives	2.98	2.92	3.22	3.27	2.50	2.80
12. Cancer Council activities have been adopted by other health agencies or institutions	3.04	2.92	3.44	3.45	2.25	2.80
13. Funding obtained to support Cancer Council activities	3.16	3.33	3.33	3.36	2.25	3.00
14. The mission of your Cancer Council is constantly refined	3.10	2.75	3.33	3.45	2.50	3.13
15. Membership includes broad-based participation from community leaders,	3.29	3.25	3.11	3.45	3.25	3.33
Development	**47.70**	**48.10**	**49.52**	**51.51**	**41.75**	**44.99**
Cronbach's Alpha	0.9201					

Ownership

The latent independent construct of Ownership consisted of an 8-item scale that yielded a significant Cronbach's Alpha of $\alpha = .8784$. Overall, aggregate participants score index for Ownership was 25.63 out of a total of 32 (80%) possible points. Overall mean indices reported per item in regard to Ownership were that: you can influence the decisions that your Cancer Council makes ($\mu = 3.16$), your Cancer Council has influence over decision that affect your life ($\mu = 3.14$), you are satisfied with the amount of influence you have over decisions that you Cancer Council makes ($\mu = 3.31$), Cancer council can influence decisions that affect the community ($\mu = 3.31$), you are satisfied with the amount influence your Cancer Council has within your community ($\mu = 3.10$), By working together, people in your community can influence decisions on the state and/ or national level ($\mu = 3.29$), people in your community work together to influence decisions on the state and/ or national level ($\mu = 3.04$), and your Cancer Council is effective in achieving its goals ($\mu = 3.27$). The level of agreement per item of the Ownership construct is displayed in the following (Figure 6):

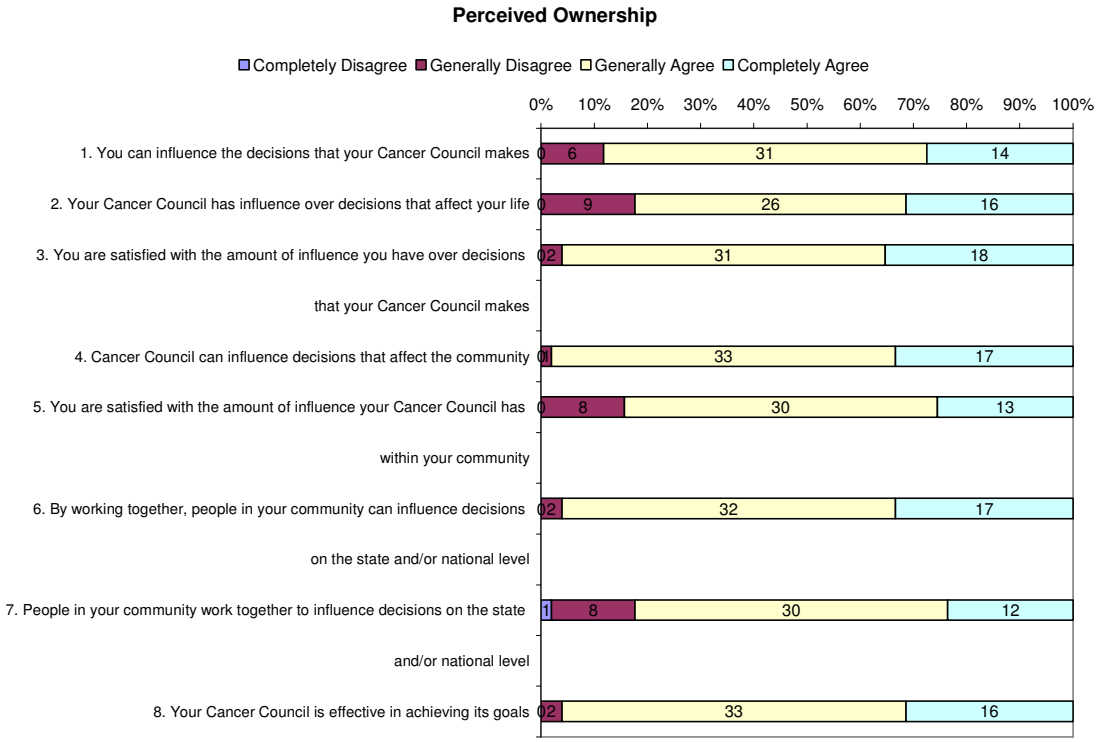


Figure 6: Perceived Ownership Scale of Agreement Distribution

When evaluating the results of the Cancer Connection program Ownership construct by individual Cancer Councils, score indices ranged from 27.22 (Cross), 26.64 (Bradley), 26.00 (Cleveland), 24.47 (Mississippi), and 22.50 (St. Francis) respectively. Mean scores per item varied greatly among local Cancer Councils in regard to their performance on individual item means. The following (Table 5) gives a description of all relative means and their impact on Ownership score indices for each local Cancer Council.

Table 5: Cancer Connection Program Assessment Perceived Ownership Mean Scores

CCPA Perceived Ownership

	Total N=51	Cleveland n=12	Cross n=9	Bradley n=11	St. Francis n=4	Mississippi n=15
1. You can influence the decisions that your Cancer Council makes	3.16	3.00	3.44	3.09	3.00	3.20
2. Your Cancer Council has influence over decisions that affect your life	3.14	3.25	3.33	3.27	2.50	3.00
3. You are satisfied with the amount of influence you have over decisions that your Cancer Council makes	3.31	3.33	3.56	3.27	3.00	3.27
4. Cancer Council can influence decisions that affect the community	3.31	3.33	3.44	3.45	3.25	3.13
5. You are satisfied with the amount of influence your Cancer Council has within your community	3.10	3.25	3.33	3.27	2.50	2.50
6. By working together, people in your community can influence decisions on the state and/or national level	3.29	3.33	3.44	3.45	3.25	3.07
7. People in your community work together to influence decisions on the state and/or national level	3.04	3.08	3.11	3.45	2.25	2.87
8. Your Cancer Council is effective in achieving its goals	3.27	3.42	3.56	3.36	2.75	3.07
Ownership	**25.63**	**26.00**	**27.22**	**26.64**	**22.50**	**24.47**
Cronbach's Alpha	0.8784					

Capacity Effectiveness

The latent independent construct of Effectiveness consisted of a 15-item scale that yielded a significant Cronbach's Alpha of $\alpha = .9317$. Overall, aggregate participants score index for Effectiveness was 47.86 out of a total of 60 (80%) possible points. Overall, mean indices reported per item in regard to Effectiveness were: understanding of community needs and assets ($\mu = 3.22$), ability to conduct a needs/ asset assessment ($\mu = 3.00$), ability to design and implement action plans (3.04), ability to evaluate progress and results ($\mu = 3.04$), ability to write grants and/ or generate resources ($\mu = 2.84$), understanding of others' perspectives ($\mu = 3.31$), ability to work with others ($\mu = 3.43$), understanding of group processes ($\mu = 3.31$), ability to communicate effectively in a group ($\mu = 3.33$), ability to help resolve group conflict ($\mu = 3.18$), ability to help a group achieve its goals ($\mu = 3.35$), leadership ability ($\mu = 3.25$), skills to influence local policies ($\mu = 3.06$), ability to help solve community problems ($\mu = 3.18$), and knowledge of resources available in the community ($\mu = 3.31$). The level of agreement per item of the Effectiveness construct is displayed in the following (Figure 7):

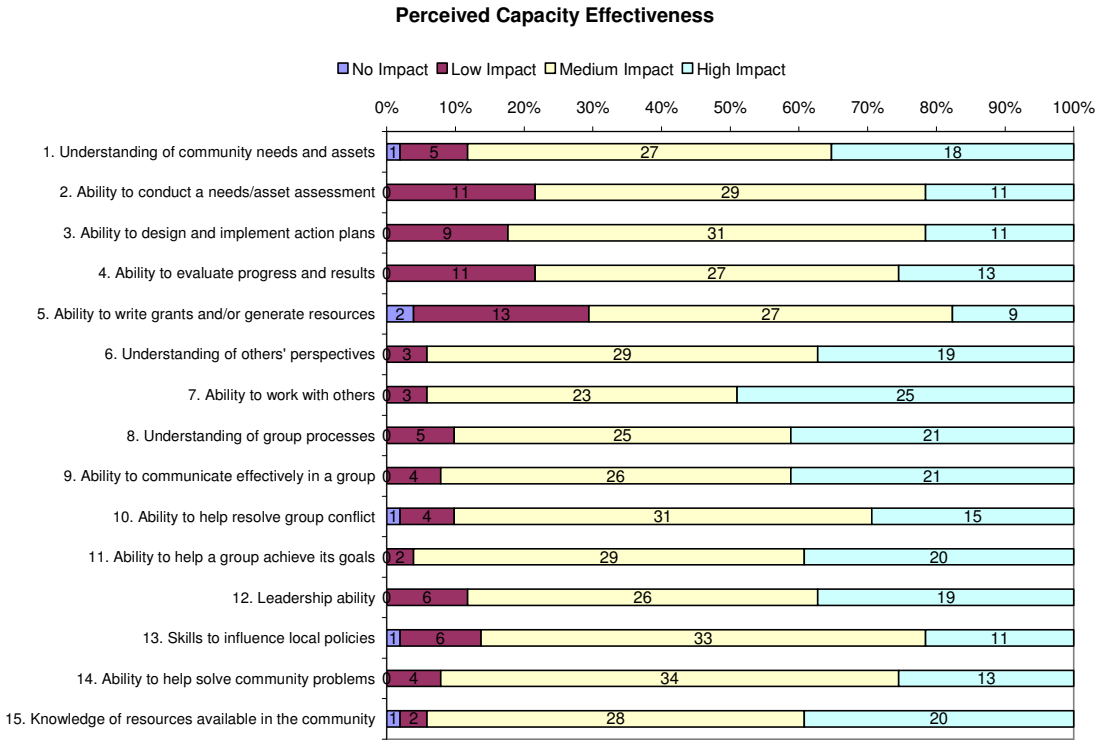


Figure 7: Perceived Capacity Effectiveness Scale of Agreement Distribution

When evaluating the results of the Cancer Connection program Effectiveness construct by individual Cancer Councils, score indices ranged from 51.73 (Bradley), 47.60 (Mississippi), 46.83 (Cleveland), 46.44 (Cross), and 44.50 (St. Francis) respectively. Mean scores per item varied greatly among local Cancer Councils in regard to their performance on individual item means. The following (Table 6) gives a description of all relative means and their impact on Ownership score indices for each local Cancer Council.

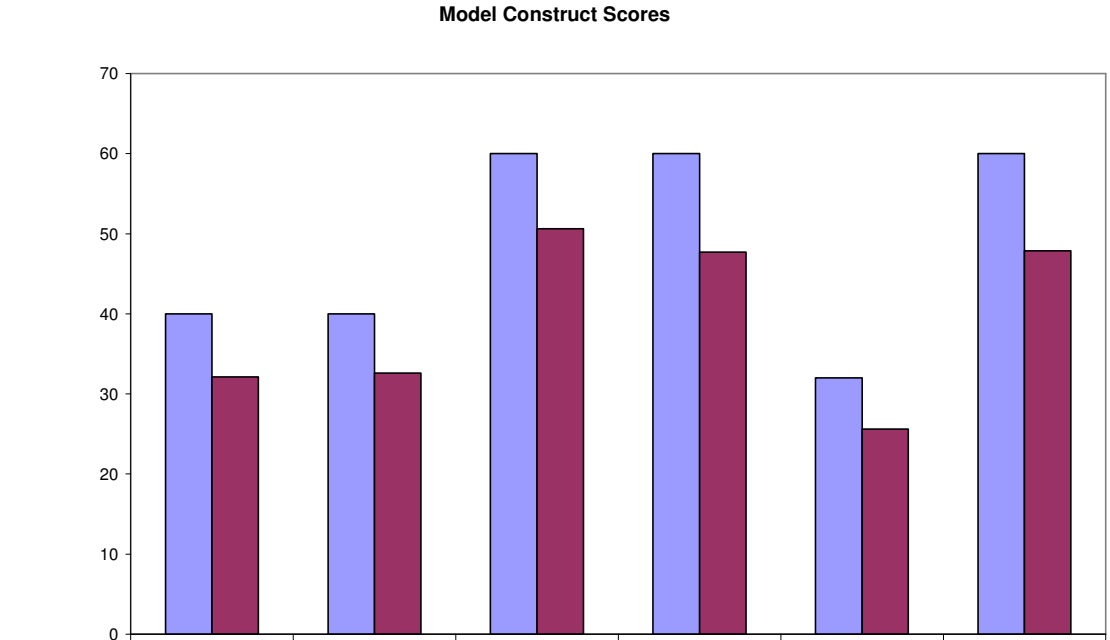
Table 6: Cancer Connection Program Assessment Perceived Capacity Effectiveness Mean Scores

CCPA Perceived Capacity Effectiveness

	Total N=51	Cleveland n=12	Cross n=9	Bradley n=11	St. Francis n=4	Mississippi n=15
1. Understanding of community needs and assets	3.22	3.25	3.11	3.45	2.75	3.20
2. Ability to conduct a needs/asset assessment	3.00	2.92	2.89	3.55	2.75	2.80
3. Ability to design and implement action plans	3.04	3.00	2.89	3.45	2.75	2.93
4. Ability to evaluate progress and results	3.04	3.17	3.11	3.36	2.25	2.87
5. Ability to write grants and/or generate resources	2.84	2.92	2.89	3.18	2.00	2.73
6. Understanding of others' perspectives	3.31	3.25	3.22	3.55	3.50	3.20
7. Ability to work with others	3.43	3.33	3.33	3.36	3.75	3.53
8. Understanding of group processes	3.31	3.17	3.33	3.27	3.50	3.40
9. Ability to communicate effectively in a group	3.33	3.08	3.11	3.55	3.50	3.47
10. Ability to help resolve group conflict	3.18	3.00	3.11	3.45	2.50	3.33
11. Ability to help a group achieve its goals	3.35	3.25	3.22	3.64	3.50	3.27
12. Leadership ability	3.25	3.08	3.22	3.45	3.25	3.27
13. Skills to influence local policies	3.06	2.92	2.89	3.36	2.50	3.20
14. Ability to help solve community problems	3.18	3.17	2.89	3.45	3.00	3.00
15. Knowledge of resources available in the community	3.31	3.33	3.22	3.64	3.00	3.20
Capacity Effectiveness	**47.86**	**46.83**	**46.44**	**51.73**	**44.50**	**47.60**
Cronbach's Alpha	0.9317					

Coalition Effectiveness Index

The Coalition Effectiveness Index is an aggregate score that combines the scores reported for all variables: Structures & Processes, Membership Engagement, Leadership, Development, Ownership, and Capacity Effectiveness. Item constructs that showed the highest fidelity (ratio of actual score by the maximum score allowed) were:



	Structures & Processes Scale	Membership Engagement Scale	Leadership Scale	Development Scale	Ownership Scale	Capacity Effectivess Scale
MAX	40	40	60	60	32	60
Overall Score	32.098	32.5882	50.6275	47.6863	25.6275	47.8627

Figure 8: Coalition Effectiveness Index Model Construct Scores

Leadership (84.4%), Member Engagement (81.5%), Structures & Processes (80.3%), Ownership (80.0%), Effectiveness (79.8%), and Development (79.5%) **(Figure 8).** Overall, the Coalition Effectiveness Index was 236.50 out of a total of 292 (81%) for the Cancer Connection program.

Results of the Coalition Effectiveness Indices by local Cancer Councils were also an aggregate score that combined the scores reported for all variables: Structures & Processes, Membership Engagement, Leadership, Development, Ownership, and Capacity Effectiveness. According to the Coalition Effectiveness Indices, the Cancer Councils that showed the highest fidelity (ratio of actual score by the maximum score allowed) were: Bradley (85.0%), Cross (83.6%), Cleveland (80.7%), Mississippi (78.7%), and St. Francis (73.5%). The following (Table 7) gives a description of all relative means and their impact on Coalition Effectiveness Index score indices for each local Cancer Council.

Table 7: Coalition Effectiveness Index Scores by Model Constructs

Coalition Effectiveness Index Score

	Total N=51	Cleveland n=12	Cross n=9	Bradley n=11	St. Francis n=4	Mississippi n=15
Structures & Processes Scale	32.10	30.33	34.22	34.00	29.25	31.60
Membership Engagement Scale	32.59	32.42	33.89	33.55	31.00	31.67
Leadership Scale	50.63	51.83	52.89	51.00	45.50	49.40
Development Scale	47.70	48.10	49.52	51.51	41.75	44.99
Ownership Scale	25.63	26.00	27.22	26.64	22.50	24.47
Capacity Effectiveness Scale	47.86	46.83	46.44	51.73	44.50	47.60
Coalition Effectiveness Index Score	**236.50**	**235.51**	**244.18**	**248.43**	**214.50**	**229.73**

Perceived Coalition Effectiveness Model Construction

The constructs that make up the aggregate latent variable of Perceived Coalition Effectiveness consisted of two sets of variables: independent (Structures & Processes, Membership Engagement, Leadership, Development, and Ownership) and dependent (Capacity Effectiveness). Significant Person correlation coefficients of the independent variable with Capacity Effectiveness from highest to lowest were r = .731 (Development), r = .689 (Ownership), r = .630 (Leadership), r = .505 (Membership Engagement), and r = .386 (Structures & Processes) **(Table 8).**

Table 8: Pearson Correlation Matrix for Structures and Processes, Membership Engagement, Leadership, Development, Ownership, and Capacity Effectiveness

	CE	SP	ME	LEA	DEV	OWN
Capacity Effectiveness	**1.00**					
Structures & Processes	***.368****	**1.00**				
Membership Engagement	***.505****	*.559*	**1.00**			
Leadership	***.630****	*.601*	*.545*	**1.00**		
Development	***.731****	*.506*	*.640*	*.759*	**1.00**	
Ownership	***.689****	*.368*	*.546*	*.657*	*.771*	**1.00**

*significance <0.05
**significance <0.001

When evaluating the hierarchal regression analysis, all combinations of the independent variables in regard to Capacity Effectives proved to be significantly significant. When all variables were entered, the adjusted R^2 was .535 with an F = 12.50 and significance at p <.000. The best five variable regression model (Ownership, Structures & Processes, Leadership, Development, and Capacity Effectiveness) yielded an adjusted R^2 of .544 with an F = 15.93 and significance at p <.000. The best four

variable regression model (Ownership, Leadership, Development, and Capacity Effectiveness) yielded an adjusted R^2 of .553 with an $F = 21.62$ and significance at $p <$ .000. The best three variable regression model (Ownership, Development, and Capacity Effectives) yielded an adjusted R^2 of .555 with an $F = 32.18$ and significance at $p <.000$. The best two variable regression model (Development and Capacity Effectives) yielded an adjusted R^2 of .524 with an $F = 56.09$ and significance at p <.000 **(Table 9).** The variable model that explained the most variance within the dependent variable Capacity Effectiveness was the three variable model with the independent variables of Development and Ownership. This model accounted for 55.5% of the variance within this study when explaining the high impact participants achieved in regard to their Capacity Effectiveness.

Table 9: Regression Model Table

Capacity Effectiveness Regression Models

Model	R	R Square	Adjusted R Square	F	Significance
All Variables	0.763	0.582	**0.535**	12.50	<.000
(5) OWN, SP, LEA, DEV	0.762	0.581	**0.544**	15.93	<.000
(4) OWN, LEA, DEV	0.761	0.580	**0.553**	21.62	<.000
(3) OWN, DEV	0.757	0.573	**0.555**	32.18	<.000
(2) DEV	0.731	0.534	**0.524**	56.09	<.000

All Variables = (Capacity Effectiveness) SP, ME, LEA, DEV, OWN
5 Variables = (Capacity Effectiveness) SP, LEA, DEV, OWN
4 Variables = (Capacity Effectiveness) LEA, DEV, OWN
3 Variables = (Capacity Effectiveness) DEV, OWN
2 Variables = (Capacity Effectiveness) DEV

DISCUSSION

The results of this study validated much of what was anecdotally presented within past studies and meta-analysis, yet there were noted differences that cannot be ignored. True to the mission and purpose of community coalitions, Cancer Connection proved to be an organization of organizations whose members committed to an agreed upon purpose in an effort to influence external behaviors related to their respective cancer control activities while maintaining their own autonomy. The level of function and purpose reported was very positive considering 55% of the membership felt Cancer Connection participants shared a common vision that linked diverse interest, actions, and resources into one collective group. The framework that provided the synergistic function of the Cancer Connection program was aided by the diverse membership of local Cancer Councils. The education levels of the participants were relatively high with approximately 63% holding at least a College Degree. The inclusion of membership representation from Business (8%) and Social Service organizations (22%) leads the way for continued sustainability and institutionalization of local Cancer Council initiatives within their respective communities. With the majority of members participating for at least the past 24 months (56%), and given the mixture of grassroots citizens and professional organizations that make up the Cancer Connection program, maintenance of local Cancer Councils have been consistent.

These particular citizens whom form this enriched Community – Academic Partnership prove to have the social capital, dedication, diversity needed to embrace and

execute their broad missions in regard to eliminating local cancer disparities while increasing community capacity and empowerment. Although there were no single collective programs guiding the participants of Cancer Connection, the impact of there participation has been enhanced.

True to the propositions that underline the Community Coalition Action Theory (CCAT), the independent variables of Structures & Processes, Membership Engagement, Leadership, Development, and Ownership all showed significant associations with Capacity effectiveness. Although technically, all participants in this study belonged to one of five subgroups (Cancer Councils), the internal reliability and consistency was very strong in the majority of the scales. With reported Cronbach's Alpha levels at .95 (Leadership), .94 (Structures & Processes), .93 (Effectiveness), .92 (Development), .90 (Membership Engagement) and .88 (Ownership), there was no bias in the form of various cluster groups (Cancer Councils) significantly responding differently within this study. The internal reliability stands rigorously when compared to similar scales and their Cronbach's Alpha levels reported previously from the review of literature. Direct comparisons of similar construct scales that can be found in the literature were as follows:

- Leadership α = .95 (Torrence) v. Leadership α =.92 (Hays et al., 2000)
- Effectiveness α = .93 (Torrence) v. Implementation Effect α = .87 (Florin et al., 2000)
- Membership Engagement α = .90 (Torrence) v. Member Participation α = .87 (Hays et al., 2000)

- Ownership $\alpha = .88$ (Torrence) v. Ownership $\alpha = .71$ (Israel et al., 1994)

The Structures & Processes of the Cancer Connection program showed above average consistency and fidelity. Particular strengths related to Cancer Connection's structures and processes were 1) that meetings were adequately scheduled, 2) resources were allocated fairly among Cancer Council initiatives and activities, and 3) effective communication protocols among member organizations were adequately established. Identified areas of improvement were 1) the need to regularly train new and old members about cancer initiatives, 2) orient new members to Cancer Council's functioning and purpose, and 3) maintain a clear mechanism to make decisions. Given the fact the areas of improvement were in themselves above the level of disagreement, Cancer Connection showed efficacy and consistency in regard to meeting the conditions of effective community coalition structures and processes : shared resources among diverse stakeholders, inter-organizational structure was equitable and democratic, and membership was totally voluntary.

Membership Engagement of participants within the Cancer Connection program showed high consistency and fidelity overall. Particular strengths were identified in regard to the memberships' 1) feeling and sense of accomplishment, 2) shared mission of their respective Cancer Councils, and 3) communication with each other. Areas for potential improve were identified in regards to 1) assuming lead responsibility for Cancer Council tasks, 2) equitably sharing the workload, and 3) seeking out training opportunities in areas related to Cancer Council activities.

Leadership effectiveness showed high consistency and fidelity overall. Particular strengths were identified in regard to Cancer Council Chairs' and Co-Chairs' 1) commitment to the mission of Cancer Connection, 2) value and treatment of members' input, and 3) flexibility in accepting different viewpoints. Areas identified for potential improvement were the leadership's 1) appropriation of time devoted to Cancer Council activities; 2) effectively and efficiently planning; and 3) promotion of equity and collaboration among members. The effectiveness of Cancer Council Chairs and Co-Chairs are highly commendable considering the fact that they are dedicated individuals whom carry out the detailed operations of their Cancer Councils totally on a voluntary basis.

Development within the Cancer Connection program showed high consistency and fidelity overall. Particular strengths were identified in regard to 1) clearly designated leadership positions, 2) dissemination of Cancer Council accomplishments with community members, and 3) broad-based participation from community leaders, professionals, and grassroots organizers representing targeted populations. Areas identified for potential improvement were 1) the level of influence over local, state, and private health agency initiatives, 2) recognition as an authority on cancer related issues, and 3) the institutionalization and adoption of Cancer Connection activities by other health agencies and institutions. Across the dimension of Development, maintenance was achieved. This was evident by the Cancer Connection's 1) sustained progression in achieving its goals, 2) keeping internal relations and connections with influential

partners and outside organizations intact, and 3) developing the trust, accountability, and contribution to overall community capacity.

The level of perceived ownership of the Cancer Connection program showed above average consistency and fidelity. Particular strengths were identified in regard to 1) satisfaction with the amount of influence individuals have over Cancer Council decisions, 2) control and influence the Cancer Council decisions have on the affect of the community, and 3) the feeling that, by working together, people in their respective communities can influence decisions on the state and/or national level. Areas identified as achieving lower levels of consistency and fidelity were the Cancer Councils': 1) belief that people in their community work together to influence decisions on the state and/or national level, 2) satisfaction with the amount of influence within their respective communities, and 3) the level of influence that Cancer Connection has over the decisions that affect their life.

The level of impact in regard to perceived capacity effectives was relatively high in consistency and fidelity. Particular strengths identified were high impacts of individual: 1) ability to work with others, 2) ability to help a group achieve its goals, and 3) ability to communicate effectively in a group. Areas identified as having lower levels of impact were the individuals': 1) ability to write grants and/or generate resources, 2) ability to conduct needs/asset assessment, and 3) ability to design, implement, and evaluate action plans. These particular areas of lower impact are of importance to the Cancer Connection program and are essential in the transfer of knowledge, skills, and sustainability from the University to the community.

When transposing the strengths and areas for potential improvement by the Cancer Connection program evaluation dimensions of organizational climate, level of collaboration, training protocols, planning and implementing, and coalitional outcomes, the apparent divisions within Coalition Effectiveness appears. Areas of particular high levels of efficacy and strength within the Cancer Connection program are displayed through the dimensions of organizational structure and the level of collaboration. Items related to organizational climate were the capacity to conduct regular scheduled meetings, effective communications, sense of shared mission, variety of individual skills, active participation, leadership guidance and commitment, and broad-based participation from diverse stakeholders within the Cancer Councils' respective communities. High Levels of collaboration were evident in the efficacy and ability of Cancer Councils to accept different viewpoints and value member input, understand community needs and assets, understand other people's perspectives and group processes, their ability to work with others, communicate effectively, and achieve their respective goals through community influence and decision-making.

When assessing areas of potential improvement with the Cancer Connection program, training protocols and planning and implementation stands out as in need of special attention and enhancement. Lower efficacies in regard to training protocols were validated by the deficiency of orientating new members, providing training on emerging cancer initiatives, and encouraging members to seek training opportunities outside of the lead agency. Planning and implementation activities showed lower levels of efficacy in the participants taking lead responsibility for Cancer Council tasks, sharing the work

load equitably, adequate time for Cancer Council activities, refining Cancer Council mission, influencing local policies, and effectively designing, implementing, and evaluating action plans.

When evaluating outcomes identified by review of the literature that measure the efficacy and morale of coalitions, Cancer Connection outcomes highlighted both strengths and areas for potential improvement. Strengths were exhibited in the participants' proximal sense of accomplishments, feeling that membership benefits outweigh the cost of membership, dissemination of accomplishment throughout the community, satisfaction with the level of influence Cancer Council decisions have made within their lives, and effectively reaching the goals of the Cancer Connection Program. Areas for potential improvement centered on the level of recognition as an authority on cancer issues, influence beyond the community level, and adoption of programs and activities by official health agencies.

When evaluating the overall performance and coalition effectiveness of the Cancer Connection Program, the Coalition Effectiveness Index (CEI) was relatively strong. The Community Coalition Action Theory constructs with the highest consistency and fidelity proved to be 1) Leadership, 2) Member Engagement), 3) Structures & Processes, 4) Ownership, 5) Effectiveness, and 6) Development respectively. The overall performance and coalition effectiveness of the local Cancer Councils themselves as reported by their respective CEIs were 1) Bradley, 2) Cross, 3) Cleveland, 4) Mississippi, and 5) St. Francis. Yet, when evaluating the performance of local Cancer Councils in regard to the dimensional variables that make up the Coalition

Effectiveness Index; the order and consistency of variable effectiveness was not uniform or representative of the order and level of overall effectiveness by respective Cancer Councils.

In the area of Structures & Processes, the reported performances of their score from highest to lowest were 1) Bradley, 2) Cross, 3) Mississippi, 4) Cleveland, and 5) St. Francis. Membership engagement effectiveness by Cancer Council from highest to lowest was 1) Bradley, 2) Cross, 3) Cleveland, 4) Mississippi, and 5) St. Francis. Leadership effectiveness yielded a rank of 1) Cross, 2) Cleveland, 3) Bradley, 4) Mississippi, and 5) St. Francis. Level of Development and maintenance was reported highest in regard to 1) Bradley, 2) Cross, 3) Cleveland, 4) Mississippi, and 5) St. Francis. The level of perceived ownership and control were highest among 1) Cross, 2) Bradley, 3) Cleveland, 4) Mississippi, and 5) St. Francis. The impact of the capacity effectiveness among Cancer Councils were highest among 1) Bradley, 2) Mississippi, 3) Cleveland, 4) Cross, and 5) St. Francis. The only constant within the order of Cancer Council effectives per construct item was that St. Francis reported the lowest level of consistency and fidelity across all CEI dimensions.

Given the significant level of the correlation relationship between the independent variables with Cancer Connection capacity effectiveness, it was not surprising that the initial regression model accounted for 54% of the variance within the dependent variable Capacity Effectiveness. Yet, the impact and order of correlation influence among the independent variables in regard to the dependent were unexpected. The strengths of association with Capacity Effectiveness among the independent

variables were Development, Ownership, Leadership, Membership Engagement, and Structures & Processes respectively. This was contrary to the review of literature, which points to Structures & Processes and Membership Engagement as being the two most important variables in predicting the effectiveness of community coalitions. Yet, one contextual difference within the Cancer Connection program that may not be a factor with other coalitions is the fact that there is no routinization or persistent implementation of uniform programs, initiatives, and activities. Thus, the level of Capacity Effectives is relative to the degree of localized action plans, which may vary in formalization and structure.

Hierarchal regression models resulted in a best model fit accounting for 56% of the variance within Capacity Effectiveness by Development and Ownership. Alone, Development accounts for 52% of the variance within Capacity Effectiveness. The implications imagined by the above associations lead to great insight in the area of coalition effectiveness. More importantly, the areas identified through this study that have the greatest impact in the improvement of overall Coalition Effectiveness within the Cancer Connection program are Capacity Effectiveness, Development, and Ownership according to there overall aggregate score index and potential for improvement across all local Cancer Councils.

Limitations

There were various limitations and delimitations within this particular study. In regard to the methodological problems evaluating coalitions highlighted throughout the

literature, precautions and acknowledges were mindful. Sample representation was of concern considering that only five of the seven Cancer Councils targeted are represented. There could be extraneous community context within those participants not represented that cause them to divert from the study population significantly. Although the reliability and consistency of the study population overall did not cause any concern. Control of the independent variables within the study was not exclusive. There was no effort or control over any exposure to experience, skills, or training of attributes that would enhance the Cancer Connection participants in regard to their localized organizational capacity. Also, definitions, titles, and usage of the variables: Development, Leadership, Structures & Processes, Membership Engagement, Ownership, Capacity Effectiveness, and the Coalition Effectiveness Index were all modifications and adaptations exclusive to this study population and may not represent their associated representation previously stated throughout published literature.

The dependant variable of Capacity Effectiveness, although general and adapted from previously published literature, may not be representative of typical results in regard to skill development and member capacity as stated throughout the literature. Because of the fluid and dynamic nature of coalition capacity building, the reported data are only perceived and are in no way actually measured by a uniform and distinct operational criteria mandated throughout the Cancer Connection Program. They are unique only to the level of locally based Cancer Council initiatives and activities, which vary from region to region.

CONCLUSION

All of the participants in Cancer Connection program have demonstrated a strong willingness to work closely with each other, and learn from each other. This program emphasizes diversity and community-academic collaboration in developing better support services for communities in the area of cancer control and prevention. The existence of community support programs provides a means of offering such effective support rapidly and inexpensively, making it available to diverse populations. The combination of this community-based effort provided the conduit for improving all existing and future programs in addition to providing evidence to support change. This was evident in the Cancer Councils' levels of overall Coalition Effectiveness.

The results of this particular study, as well as others in the literature prove to be significant on a number of fronts. Specifically, these studies present needed information and validation not only for coalition participants, but also for funding agencies and professional evaluators. It is evident of the diverse benefits and skills awarded coalition participants by the results of this study. Yet, in the areas that were important to the funding agencies and evaluators perspectives, the Cancer Connection program showed high levels of membership accountability and effectiveness.

The councils continue to establish a number of successful collaborations and receive substantial community support. One of the collaborations includes strengthening the relationship with the statewide Hometown Health Initiative of the Arkansas Department of Health. This collaboration will increase participation and help build on

the infrastructure of the Cancer Councils. Cancer Councils are also soliciting funds on their own. Collectively, local Cancer Councils have received extramural funding which comes to a total of approximately $48,000. The significance of the above highlights the continuous goals of community capacity and empowerment by helping communities become independent of the community – academic partnerships that started them.

Although the interaction between community-based researchers located at the Universities and the communities that surround them have always existed, the nature of the interaction has changed. As community-based researchers began to acknowledge the distinct community characteristics that exist within communities, local communities have also began to recognized their own skills, abilities, and passions as being key determinants of community programs and health outcomes. The growing popularity of Community-Based Participatory Research (CBPR) has caused University Academics to rethink their relationship with the community, not in lateral terms, but in horizontal terms. No longer can the University's commitment to the community be a direct relationship between the researcher and the study population. This relationship has to evolve into a true partnership that has a three-way interaction among the researcher, community, and the students of the University.

The first duty of the University researchers, in their effort to increase the capacity and development of knowledge and skills within the local community should focus on their students. In order for students in Health Education to become effective practitioners in the area of coalition development and capacity building, they must learn

to facilitate the internal and external support functions related to community coalitions. Graduates of Health Education and Promotion programs must (Poole, 1997):

- Facilitate the process of forming community coalitions that address broad-based social and public health needs
- Develop effective leadership qualities and secure broad-based community participation in the decision-making processes
- Create new organizational arrangements that span professional disciplines and agency domains
- Perform mediating functions that lead to productive relationships among civic leaders, client groups, business organizations, faith communities, nonprofit agencies, and public health agencies
- Strengthen the problem-solving capabilities of coalitions by assisting them in identifying and analyzing social and public health problems, setting operational goals and priorities, considering multiple alternative interventions, and making decisive plans of action
- Perform activities necessary to implement decisions, evaluate outcomes, and sustain commitment towards continuously solving the communities health problems

The second, although no less important than the first, duty of the University researchers is to establish community capacity-building institutes directly within community coalitions. The direct enhancement of community empowerment and

capacity building can be achieved via community-academic partnerships that (Poole, 1997):

- Train coalition leadership to form and sustain community action structures
- Train students from relevant health related disciplines to provide support services to staff and lay coalition leaders involved in community health development
- Monitor and evaluate community health outcomes related to the efforts of the coalition
- Disseminate findings to local, state, regional, and national audiences
- Advise policy-makers on ways to achieve broad-based social goals and outcomes through community coalitions

The underlining responsibility of Health Education and Promotion is to organize the community in such a way that will empower individuals of the community to live healthier productive lives. Community organization and coalition building are crucial to the role of the responsible health educator/promoter. Health educators/promoters identify common goals related to priority health issues and populations, develop strategies to intervene or prevent the ill effects of the priority health issues, and mobilize the necessary resources needed to sustain the positive benefits of the intervention or prevention. Another important role of the health educator/promoter is community empowerment. Community empowerment enables the community to increase its own control over the determinants of its own health. As stated throughout this manuscript, coalitions also perform the crucial role of community empowerment. In order for the

field of Health Education and Promotion to advance, it has to perfect the art of coalition building, maintenance, and institutionalization. As the focus of health education and promotion turns away from individual level interventions to multilevel interventions that include organizational and interorganizational level interventions, coalitions will become a staple within the professional health educator's toolbox.

Many of the tools necessary to manage coalitions are currently already taught to students of health education and promotion. When looking at the responsibilities and competencies that entry level health educators should possess:

Responsibility I – Assessing individual and community needs for health education

Responsibility II—Planning effective health education programs

Responsibility III—implementing health education programs

Responsibility IV—Evaluating effectiveness of health education programs

Responsibility V—Coordinating provision of health education services

Responsibility VI—Acting as a resource person in health education

Responsibility VII—Communicating health education needs, concerns, and resources

Health educators are equipped with the fundamental assets needed for effective coalitions. According to the manual *A Competency-Based Curriculum Framework for the Professional Preparation of Entry-Level Health Educators*, the goal of health education is to promote, maintain, and improve individual and community health through the educational process. The conceptual hallmarks and social agenda that distinguish the practice of health education and promotion from that of other helping professions in achieving this goal include: 1) using consensus to identify health needs

and problems; 2) voluntariness of participation as an ethical requirement; and 3) a focus on stimulating social and organizational behavior change in defined populations. Health education and promotion is primarily interested in giving people the empowered role of defining their own problems, setting their own priorities, and creating the practical solutions by which they achieve a sense of interest in, commitment to, and ownership over the efforts used to address health issues.

Within the paradigm that health educators work from, community coalitions will be the catalyst and link between the health promotion activities of public health with the service, medical orientation of public health and medicine. As the shift form the medical model of health to the social model of health matures, coalitions will play a major role not only for the delivery of innovative interventions, but also as a research mechanism whereby community-based participatory research can be performed efficiently and with scientific rigor. Already, the majority of program announcements (PA), request for proposals (RFP), and request for applications (RFA) from the National Institutes of Health (NIH), Center for Disease Control and Prevention (CDC), and the Department of Health and Human Services (DHHS) call for some type of collaborations that essentially lead to coalition formation in regard to community-based participatory research. As stated throughout this manuscript, the overwhelming majority of coalitions get their start and support form lead agencies and funding agencies who direct the purpose and mission of the coalition. The health education and promotion professional who is equipped to build, maintain, and institutionalize coalitions and coalitional interventions will be a very attractive resource in the field of Public Health.

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APPENDIX A
Assessment Proctor

"Helping Communities Fight Cancer"

Cancer Control Outreach Center
Arkansas Cancer Research Center
University of Arkansas for Medical Sciences

Supported by:
The Roy and Christine Sturgis
Charitable and Educational Trust
&
Electric Cooperatives of Arkansas

Assessment Proctor

Introduction

In an effort to strengthen the relationship between the Cancer Connection program and your local Cancer Council, we ask for your participation, and completion of this Cancer Connection Program Assessment. This assessment will help us better understand your Cancer Council's organizational strengths and capacities in an effort to highlight those organizations traits in which we at ACRC can maximize and enhance.

After completion of the survey, you will receive a gift incentive for your effort and support. Completion of the anonymous pencil and paper survey is not mandatory and will in no way affect member status within the Cancer Connection program, nor will individual information be highlighted. Yet, receipt of your gift incentive is contingent upon your completed assessment.

The most significant benefit of your participation will be the synergistic enhancement of the level of communications, resource sharing, and technical assistance provided between ACRC and your individual Cancer Councils, as well as among local Cancer Councils with similar goals, initiatives, and geographical locations.

General Questions (1-10) – pgs 1&2

Cancer Councils are represented by members who are formally, or informally, representing other community and governmental organizations that are interested in the quality of Cancer Control activities within their respective communities. This section will help us understand the membership make-up of your Cancer Council by providing us with your individual association with the Cancer Council, as well as the diverse demography that each of you represent. After completion of Q10, please await instructions!

Organizational Structures & Processes (11-20) – pg 3

The success of your Cancer Council may depend on how members of the council work together as a team. Different councils come up with different ways to get organized, work on a problem, and help the community. There may not be a single best way to organize a cancer council. This next section will help us understand how this Cancer Council is organized. How do you identify problems? How do you set priorities? How do you make decisions? How do you work together as a group?

We want to learn more about how different councils are organized, so we can help people work together more effectively, and accomplish more in their communities. Think about the way YOUR Cancer Council works. Read each statement below. If you think that, the statement is NOT a good description of your council- you may completely disagree and circle the number 1. If you think that, the statement IS a good description of your council- you may completely agree and circle the number 4. You can circle the

2 or 3 if you are somewhere in between. This is your opinion, and that may be different from someone else's opinion. Are there questions? After completion of Q20, please await instructions!

Membership Engagement (21-30) – pg 4

We recognize that YOUR local Cancer Council represent a diverse section of grassroots organizations committed to the health of your local community. Not every Cancer Council has the same exact community representation through its membership, yet the diverse views, perspectives, and resources individual members' exhibit are priceless. This section will help us understand how your Cancer Council membership as a whole interacts. Do all members have the same mission? Is the work of your Cancer Council equally performed throughout the membership?

We want to learn more about YOUR view of how engaged the collective membership of your Cancer Council is, so we can help members work together more effectively, and accomplish more in their communities. Think about YOUR Cancer Council membership make-up. Read each statement below. If you think that, the statement is NOT a good description of your collective membership- you may completely disagree and circle the number 1. If you think that, the statement IS a good description of your council- you may completely agree and circle the number 4. You can circle the 2 or 3 if you are somewhere in between. This is your opinion, and that may be different from someone else's opinion. Are there questions? After completion of Q30, please await instructions!

Leadership (31-45) – pg 5

The voluntary nature of the Cancer Connection Program ensures that many of its participants are truly passionate and committed to enhancing the health of their local communities. Although the work of your Cancer Council can be intense at times, the rewards are countless. Recognizing that the leadership of each Cancer Council varies according attributes desired among local Cancer Councils, we would like to learn about the various qualities that you feel your Cancer Council Chair and Co-chairs posses. What is the level of their commitment? Do they exhibit proficient qualities and skills?

We want to learn more about the qualities of your Cancer Council leadership, so we can help build and transfer the skills that will maximize the effectiveness of your Cancer Council leadership. Think about the way YOUR Cancer Council Chairs and Co-chairs works. Read each statement below. If you think that the statement is NOT a good description of your LEADERSHIP, you may completely disagree and circle the number 1. If you think that, the statement IS a good description of your LEADERSHIP- you may completely agree and circle the number 4. You can circle the 2 or 3 if you are

somewhere in between. This is your opinion, and that may be different from someone else's opinion. Are there questions? After completion of Q45, please await instructions!

Development (46-60) – pg 6

Given the dynamic nature of your Cancer Council, it is understood that continuous interest and stability has to be maintained. Many members represent diverse grassroots and governmental organizations with individual goals that are constantly refined and changed. Although the visibility of the work of various Cancer Councils differs, all strive to become a solid voice and vehicle for cancer control within their various communities. This section will help us understand how the growth and impact of your local Cancer Council is developing.

Considering the possibility that Cancer Councils develop in specific stages and recycle through these stages as new members are recruited, action plans are renewed, and new issues are added; we want to learn more about how different councils developing so we can help institutionalize the exceptional work of your local Cancer Council within your community. Think about the way YOUR Cancer Council works. Read each statement below. If you think that, the statement is NOT a good description of your council- you may completely disagree and circle the number 1. If you think that, the statement IS a good description of your council- you may completely agree and circle the number 4. You can circle the 2 or 3 if you are somewhere in between. This is your opinion, and that may be different from someone else's opinion. Are there questions? After completion of Q60, please await instructions!

Ownership (61-68) – pg 7

Because of the grassroots nature of many Cancer Councils, ownership of its work may be directly, or indirectly shared you or your local communities. YOUR level of personal influence over your Cancer Council may not be the same as the level of influence the Cancer Council has over YOU, or your COMMUNITY. What influence does the Cancer Council have on your personal decisions? To what extent does the influence of your Cancer Council reach?

We want to learn more about the level of ownership YOU share with your Cancer Council. Think about the influence YOU observe because of your Cancer Council works. Read each statement below. If you think that, the statement is NOT a good description INFLUENCE you may completely disagree and circle the number 1. If you think that, the statement IS a good description of INFLUENCE- you may completely agree and circle the number 4. You can circle the 2 or 3 if you are somewhere in between. This is your opinion, and that may be different from someone else's opinion. Are there questions? After completion of Q68, please await instructions!

Effectiveness (69-83) – pg 8

Individual growth and development is often a by-product of community advocacy and service. Although each member interacts and receives varying degrees of knowledge, skills, and abilities, the intrinsic rewards are often just a great as the extrinsic rewards and accomplishments of the work of the Cancer Council. This section will help understand the level of impact your Cancer Council has had on your personal knowledge, skills, and abilities related to health advocacy.

We want to learn more about the impact of knowledge, skills, and abilities possessed, so we can help YOU as an individual maximize your effectiveness within your communities. Think about YOUR knowledge, skills, and beliefs. Read each statement below. If you think that, the statement is NOT a good description Cancer Council IMPACT- circle the number 1. If you think that, the statement IS a description of HIGH IMPACT- circle the number 4. You can circle the 2 or 3 if the level of impact was somewhere in between. This is your opinion, and that may be different from someone else's opinion. Are there questions? After completion of Q83, please await instructions!

Open Ended Discussion (84-88) – p 9

The following questions required that you reflect on your collective experience and interaction with YOUR local Cancer Council, as well as your collective experience and interaction with UAMS and its Cancer Connection Program. This is your opinion, and it may be different from the opinion of group, or someone else's opinion. Your responses to these questions will be used as a starting point for the discussion that will take place following the collection of all individually completed assessments. Are there questions? After completion of Q88, please await instructions!

Conclusion

Thank you for your valuable time and commitment, if for some reason your assessment is not completely filled out, please take the time now and complete accordingly. Now turn in your completed assessment and sign for your gift incentive!

APPENDIX B
Cancer Connection Program Assessment

"Helping Communities Fight Cancer"

Cancer Control Outreach Center
Arkansas Cancer Research Center
University of Arkansas for Medical Sciences

Supported by:
The Roy and Christine Sturgis
Charitable and Educational Trust
&
Electric Cooperatives of Arkansas

1. Which of the following best describes your local Cancer Council (check ONE):
   ____ Members interact primarily for the purpose of exchanging information and communication.
   ____ Members provide helpful resources to support each other's interests and goals; there is some joint planning and activity, but resources are separate.
   ____ Members work together on goals that are complementary; there is coordination and some sharing of resources.
   ____ Members share (or are working toward) a common vision that links diverse interests; actions are jointly created and resources, and authority and decision-making are controlled in the group.

2. Who do you primarily represent as a member of your Cancer Council (check ONE):

_____	Business	_____	Higher education	Social Services Organization:
_____	Law enforcement	_____	Parent	_____ Public
_____	Justice System	_____	Concerned citizen	_____ Private, non-profit
_____	Elected official	_____	Senior citizen	_____ Private, for profit
_____	Health/medical	_____	Extension	_____ Other _____
_____	Mental health	_____	Religious organization	
_____	Day care/child care/ Head Start			
_____	School, PreK-12			

3. How long have you participated in your local Cancer Council?_____ YEARS_____ MONTHS

4. What kind of roles have you played in the past 6 months and before then in your local Cancer Council? (Circle YES or NO in each column for each item.)

	Past 6 Months		Before Then	
Attend meetings regularly	YES	NO	YES	NO
Talk at meetings (make comments, express ideas, etc.)	YES	NO	YES	NO
Serve as a member of a activities committee	YES	NO	YES	NO
Work for the Cancer Council outside of meetings	YES	NO	YES	NO
Help organize Cancer Council activities (other than meetings)	YES	NO	YES	NO
Direct the implementation of a particular program/ activity	YES	NO	YES	NO

5. During the past 12 months about how many hours, in an average month, have you given to your local Cancer Council concerning the following activities (including face-to-face and phone contacts). Please fill in the number of hours for each activity.

   _____ hours for regular Cancer Council meetings
   _____ hours for Cancer Council sponsored activities outside of meetings
   _____ hours for preparation for meetings or activities
   _____ hours for administration, paperwork
   _____ hours for networking and communicating outside of meetings
   _____ hours in facilitating group process
   _____ hours in fund raising, including grant writing
   _____ Other activities not mentioned above. Please list_____

6. In which of these groups is your age? ___under 30___30 to 44 ___45 to 64 ___65 or older

7. Are you male or female? ___Male ___Female

8. What is the highest level of formal Education achieved?

   ___High School Diploma/General Diploma ___Some College ___College Graduate
   ___Graduate School (MPH, M.S. M.ED, MA, etc.) ___Post Graduate School (Ph.D., M.D., Ed.D, J.D., etc.)

9. Which category would you say you most identify with?

   ___White
   ___Black
   ___Hispanic
   ___Asian (or Pacific Islander)
   ___Native American Indian

10. What is the five (5) digit zip code of your current residency? _____

Structures & Processes

Often, a coalition's success is dependant upon its organizational efficiency and capacity. Thinking about YOUR local Cancer Council's structures and processes, to what extent do you **agree or disagree** with the statements that your Cancer Council…

		Completely Disagree	Generally Disagree	Generally Agree	Completely Agree
11.	Has a clear mission statement in writing……..	1	2	3	4
12.	Has clear goals and objectives in writing……..	1	2	3	4
13.	Provides for regular, structured meetings……..	1	2	3	4
14.	Establishes effective communication protocols among members……	1	2	3	4
15.	Has an organized mechanism to make decisions……	1	2	3	4
16.	Has a mechanism to solve problems and resolve conflicts……..	1	2	3	4
17.	Allocates resources fairly among initiatives……..	1	2	3	4
18.	Assures that members complete assignments in timely manner……..	1	2	3	4
19.	Orients new members to Cancer Council's functioning and purpose…….	1	2	3	4
20.	Regularly trains new and old members about cancer initiatives……..	1	2	3	4

Membership Engagement

What a group accomplishes is often related to the collective participation of each individual member. Concerning YOUR local membership make-up, to what extent do you **agree or disagree** that Cancer Council Members…

		Completely Disagree	Generally Disagree	Generally Agree	Completely Agree
21.	Share the mission of the Cancer Council……..	1	2	3	4
22.	Offer a variety of individual resources and skills……..	1	2	3	4
23.	Clearly understand their individual roles……..	1	2	3	4
24.	Actively plan, implement, and evaluate cancer initiatives and activities……	1	2	3	4
25.	Assume lead responsibility for Cancer Council tasks……..	1	2	3	4
26.	Share workload equitably……..	1	2	3	4
27.	Regularly participate in meetings and cancer initiatives and activities……	1	2	3	4
28.	Communicate well with each other……..	1	2	3	4
29.	Feel a sense of accomplishment……..	1	2	3	4
30.	Seek out training opportunities in areas related to Cancer Council activities……	1	2	3	4

Leadership

The success of your local Cancer activities and initiatives often relies heavily on the support and guidance of the Cancer Council leadership. To what extent do you **agree or disagree** that YOUR local Cancer Council Chairs and Co-chairs are…

		Completely Disagree	Generally Disagree	Generally Agree	Completely Agree
31.	Committed to the mission of the Cancer Council	1	2	3	4
32.	Provide leadership and guidance in maintaining the Cancer Council	1	2	3	4
33.	Have appropriate time to devote to Cancer Council activities	1	2	3	4
34.	Plan effectively and efficiently	1	2	3	4
35.	Knowledgeable about cancer initiatives and collaborations	1	2	3	4
36.	Flexible in accepting different viewpoints	1	2	3	4
37.	Promote equity and collaboration among members	1	2	3	4
38.	Proficient in organizational and communication skills	1	2	3	4
39.	Value member's input	1	2	3	4
40.	Recognize members for their unique contributions	1	2	3	4
41.	Competent in negotiating, solving problems, and resolving conflicts	1	2	3	4
42.	Attentive to individual member concerns	1	2	3	4
43.	Effective in managing meeting	1	2	3	4
44.	Proficient in gathering external resources	1	2	3	4
45.	Work within influential political and community networks	1	2	3	4

Development

Often, a coalitions development is related to its continued effectiveness and impact within its community. Concerning YOUR local Cancer Council, to what extent do you **agree or disagree** that your…

		Completely Disagree	Generally Disagree	Generally Agree	Completely Agree
46.	Leadership positions are clearly designated	1	2	3	4
47.	Local Needs Assessment have been conducted	1	2	3	4
48.	Action plans for implementation of CANCER related activities are developed	1	2	3	4
49.	Action plans are implemented as planned	1	2	3	4
50.	Action plans are revised as necessary	1	2	3	4
51.	Financial and material resources are secured	1	2	3	4
52.	Cancer Council is broadly recognized as authority on issues related to cancer	1	2	3	4
53.	Membership benefits outweigh the cost of membership	1	2	3	4
54.	Cancer Council accomplishments are shared with community members	1	2	3	4
55.	Cancer Council is included in other external community collaborative efforts	1	2	3	4
56.	Cancer Council has influence over local, state, and private health agency initiatives	1	2	3	4
57.	Cancer Council activities have been adopted by other health agencies or institutions	1	2	3	4
58.	Funding has been obtained to support Cancer Council activities	1	2	3	4
59.	The mission of your Cancer Council is constantly refined	1	2	3	4
60.	Membership includes broad-based participation from community leaders, professionals, and grass-roots organizers representing targeted population	1	2	3	4

Ownership

Often, the level of coalition control and influence are related to the coalition's ownership of the communities' concerns. Concerning your INDIVIDUAL role with your local Cancer Council, to what extent do you **agree or disagree** that…

		Completely Disagree	Generally Disagree	Generally Agree	Completely Agree
61.	You can influence the decisions that your Cancer Council makes	1	2	3	4
62.	Your Cancer Council has influence over decisions that affect your life	1	2	3	4
63.	You are satisfied with the amount of influence you have over decisions that your Cancer Council makes	1	2	3	4
64.	Cancer Council can influence decisions that affect the community	1	2	3	4
65.	You are satisfied with the amount of influence your Cancer Council has within your community	1	2	3	4
66.	By working together, people in your community can influence decisions on the state and/or national level	1	2	3	4
67.	People in your community work together to influence decisions on the state and/or national level	1	2	3	4
68.	Your Cancer Council is effective in achieving its goals	1	2	3	4

Effectiveness

Your participation with your local cancer activities may have influenced your personal knowledge, beliefs, or skills. To what IMPACT would you say your participation in your local Cancer Activities and Initiatives have had in terms of YOUR…

		NO Impact	Low Impact	Medium Impact	High Impact
69.	Understanding of community needs and assets	1	2	3	4
70.	Ability to conduct a needs/asset assessment	1	2	3	4
71.	Ability to design and implement action plans	1	2	3	4
72.	Ability to evaluate progress and results	1	2	3	4
73.	Ability to write grants and/or generate resources	1	2	3	4
74.	Understanding of others' perspectives	1	2	3	4
75.	Ability to work with others	1	2	3	4
76.	Understanding of group processes	1	2	3	4
77.	Ability to communicate effectively in a group	1	2	3	4
78.	Ability to help resolve group conflict	1	2	3	4
79.	Ability to help a group achieve its goals	1	2	3	4
80.	Leadership ability	1	2	3	4
81.	Skills to influence local policies	1	2	3	4
82.	Ability to help solve community problems	1	2	3	4
83.	Knowledge of resources available in the community	1	2	3	4

APPENDIX C
Coalition Self-Assessment Tool (Goldstein 1997)

ASSESSMENT SCHEME: Check one choice for each characteristic	
0	**Characteristic is absent**
1	**Characteristic is present but limited**
2	**Characteristic is present**
N/A	**Characteristic not applicable at this stage of coalition**

COALITION CHARACTERISTICS **I. COALITION PARTICIPANTS**	**Assessment**				
	0	**1**	**2**	**N/A**	**Score 0-2**
Lead Agency					
1. Decision-makers are committed to and supportive of coalition					
2. Commits personnel and financial resources to coalition					
3. Knowledgeable about coalitions					
4. Experienced in collaboration					
5. Replaces agency representative if vacancy occurs					
Staff					
1. Knowledgeable about coalition-building process					
2. Skillful in writing proposals and obtaining funding/resources					
3. Trains members as appropriate					

4. Competent in needs assessment and research					
5. Encourages collaboration and negotiation					
6. Communicates effectively with members					

Butterfoss, F. D., Center for Pediatric Research; Center for Health Promotion, South Carolina DHEC, 1994. Revised 1998.

COALITION CHARACTERISTICS	**Assessment**				
	0	**1**	**2**	**N/A**	**Score 0-2**
Leaders: (Chairs and Vice-Chairs of Steering and Standing Committees)					
1. Committed to coalition's mission					
2. Provide leadership and guidance in maintaining coalition					
3. Have appropriate time to devote to coalition					
4. Plan effectively and efficiently					
5. Knowledgeable about content area					
6. Flexible in accepting different viewpoints					
7. Demonstrate sense of humor					
8. Promote equity and collaboration among members					
9. Adept in organizational and communication skills					
10. Work within influential political and community networks					
11. Competent in negotiating, solving problems and resolving conflicts					
12. Attentive to individual member concerns					
13. Effective in managing meetings					
14. Adept in garnering resources					
15. Value members' input					
16. Recognize members for their contributions					

Members					
1. Share coalition's mission					
2. Offer variety of resources and skills					
3. Clearly understand their roles					
4. Actively plan, implement and evaluate activities					
5. Assume lead responsibility for tasks					
6. Share workload					
7. Regularly participate in meetings and activities					

Butterfoss, F. D., Center for Pediatric Research; Center for Health Promotion, South Carolina DHEC, 1994. Revised 1998.

COALITION CHARACTERISTICS	Assessment				
	0	1	2	N/A	Score 0-2
Members (Continued)					
8. Communicate well with each other					
9. Feel a sense of accomplishment					
10. Seek out training opportunities					
II. COALITION STRUCTURES					
1. Bylaws/rules of operation					
2. Mission statement in writing					
3. Goals and objectives in writing					
4. Provides for regular, structured meetings					
5. Establishes effective communication mechanisms					
6. Organizational chart					
7. Written job descriptions					
8. Core planning group (e.g. steering committee)					
9. Subcommittees					
III. COALITION PROCESSES					
1. Has mechanism to make decisions, e.g. voting					
2. Has mechanism to solve problems and resolve conflicts					
3. Allocates resources fairly					
4. Employs process and impact evaluation methods					
5. Conducts annual action planning session					
6. Assures that members complete assignments in timely manner					

7. Orients new members					
8. Regularly trains new and old members					

Butterfoss, F. D., Center for Pediatric Research; Center for Health Promotion, South Carolina DHEC, 1994. Revised 1998.

IV. STAGES OF COALITION DEVELOPMENT	Assessment				
	0	1	2	N/A	Score 0-2
Formation					
1. Permanent staff designated					
2. Broad-based membership includes community leaders, professionals, and grass-roots organizers representing target population					
3. Designated office and meeting space					
4. Coalition structures in place					
Implementation					
1. Coalition processes in place					
2. Needs assessment conducted					
3. Strategic plan for implementation developed					
4. Strategies implemented as planned					
Maintenance					
1. Strategies revised as necessary					
2. Financial and material resources secured					
3. Coalition broadly recognized as authority on issues it addresses					
4. Number of members maintained or increased					
5. Membership benefits outweigh costs					
6. Coalition accessible to community					
7. Accomplishments shared with members and community					
Institutionalization					
1. Coalition included in other collaborative efforts					
2. Sphere of influence includes state and private					

agencies and governing bodies					
3. Coalition has access to power within legislative and executive branches of agencies/government					
4. Activities incorporated within other agencies or institutions					
5. Long term funding obtained					
6. Mission is refined to encompass other issues and populations					

APPENDIX D
Perceived Control Items: Multiple Levels of Empowerment Indices
(Israel et. al, 1994)

1. I can influence the decisions that this organization makes.
2. This organization has influence over decisions that affect my life.
3. This organization is effective in achieving its goals.
4. This organization can influence decisions that affect the community.
5. I am satisfied with the amount of influence I have over decisions that this organization makes.
6. I have control over the decisions that affect my life.
7. My community has influence over decisions that affect my life.
8. I am satisfied with the amount of control I have over decisions that affect my life.
9. I can influence decisions that affect my community.
10. By working together, people in my community can influence decisions that affect the community.
11. People in my community work together to influence decisions on the state or national level.
12. I am satisfied with the amount of influence I have over decisions that affect my community.

APPENDIX E
Impact of Group on Members (Taylor-Powell et al. 1998)

To what extent did the community group have an IMPACT ON YOU in terms of...

	IMPACT						
	LOW				HIGH	Uncertain	N/A
a) My understanding of community needs and assets	1	2	3	4	5	U	N/A
b) My knowledge of resources available in the community	1	2	3	4	5	U	N/A
c) My sense that together we can make a difference	1	2	3	4	5	U	N/A
d) My knowledge of ways to respond to community issues	1	2	3	4	5	U	N/A
e) My ability to conduct a needs/asset assessment	1	2	3	4	5	U	N/A
f) My ability to design and implement action plans	1	2	3	4	5	U	N/A
g) My ability to evaluate progress and results	1	2	3	4	5	U	N/A
h) My ability to write grants and/or generate resources	1	2	3	4	5	U	N/A
i) My understanding of others' perspectives	1	2	3	4	5	U	N/A
j) My ability to work with others	1	2	3	4	5	U	N/A
k) My understanding of group processes	1	2	3	4	5	U	N/A
l) My ability to communicate effectively in a group	1	2	3	4	5	U	N/A
m) My ability to help resolve group conflict	1	2	3	4	5	U	N/A
n) My ability to help a group achieve its goals	1	2	3	4	5	U	N/A
o) My leadership ability	1	2	3	4	5	U	N/A
p) My skills to influence local policies	1	2	3	4	5	U	N/A
q) My ability to help solve community problems	1	2	3	4	5	U	N/A
r) Other (please specify)_____							

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Ph.D. Health Education, *Community Health*, (Summa Cum Laude)
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Cancer Council Tobacco Initiative. Local Coalitions & Community-based Programs. University of Arkansas, Pine Bluff Minority Initiative Stamp Out Smoking Sub-Recipient Grant Office.

Role: Consultant/ Evaluator Ongoing: 07-01-2005 to 06-30-2006
PI: Ronda Henry-Tillman, MD
Amount: *$59,345.00*

A Model for Perceived Coalition Effectiveness: The Relationship of Coalition Variables to Predict Cancer Councils Organizational Capacity to Achieve Effective Community Outcomes. University of Arkansas for Medical Sciences, Arkansas Cancer Research Center, National Cancer Institute: Arkansas Special Access Population Network (ASPAN).

Role: Principal Investigator Completed: 9-06-2004 to 8-01-05
Amount: *$32,500.00*

An Assessment of the Leading Prostate Cancer Websites: What Exactly Are They Saying? Baylor College of Medicine, Houston, TX.

Role: Principal Investigator Completed: 09-01-2002 to 03-31-2003
Amount: *$2,500.00*

MANUSCRIPTS/ PUBLICATIONS (selected)

Torrence, W., Phillips, D., Guidry, J.J. (2005). The Assessment of Rural African American Churches' Capacity to Conduct Health Prevention Activities. *American Journal of Health Education*, *36*(3), p161-164.